ANNUAL REPORT OF

THE JOINT COMMISSION ON HEALTH CARE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 64

COMMONWEALTH OF VIRGINIA
RICHMOND
1995

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

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May 22, 1995

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TO: The Honorable George F. Allen, Governor of Virginia
and Members of the General Assembly

Pursuant to the provisions of the Code of Virginia (Title 9, Chapter 38, §§9-311 through 9-316) establishing the Joint Commission on Health Care and setting forth its purpose, I have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 1994.

In past years, the Joint Commission's annual report included the findings and recommendations from each of the individual studies conducted throughout the year. However, during 1994 a separate report was published as a House or Senate document for each study the Joint Commission conducted pursuant to a joint study resolution. Therefore, this annual report is more streamlined than in past years.

This 1994 annual report includes a summary of the Joint Commission's 1994 activities and legislative recommendations to the 1995 General Assembly, and an overview of health care issues facing Virginia and the nation. Copies of the legislation sponsored by the Joint Commission and passed by the 1995 General Assembly also are included.

The report was finalized in May, 1995 to include the final actions of the Governor and 1995 General Assembly on the Joint Commission's recommendations.

Sincerely,

Jay W. DeBoer

Jay W. DeBoer
Chairman

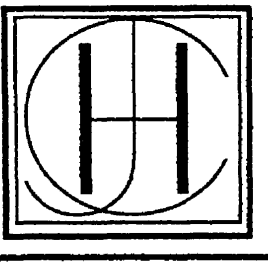
JOINT COMMISSION ON HEALTH CARE

Chairman
The Honorable Jay W. DeBoer

Vice Chairman
The Honorable Elliot S. Schewel

The Honorable Hunter B. Andrews
The Honorable Clarence A. Holland
The Honorable Edward M. Holland
The Honorable Benjamin J. Lambert, III
The Honorable Stanley C. Walker
The Honorable Jane H. Woods
The Honorable Thomas G. Baker, Jr.
The Honorable Robert B. Ball, Sr.
The Honorable David G. Brickley
The Honorable Julia A. Connally
The Honorable George H. Heilig, Jr.
The Honorable Kenneth R. Melvin
The Honorable Harvey B. Morgan
The Honorable Thomas W. Moss, Jr.

Secretary of Health and Human Resources
The Honorable Kay Coles James



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Acknowledgements

The Joint Commission extends its sincere appreciation to the Office of the Clerk of the Senate, the Office of the Clerk of the House of Delegates, the Division of Legislative Services, and the Division of Legislative Automated Systems for their assistance and support throughout 1994.

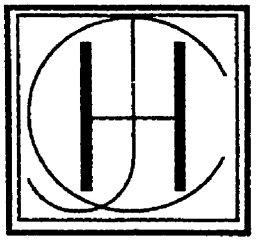
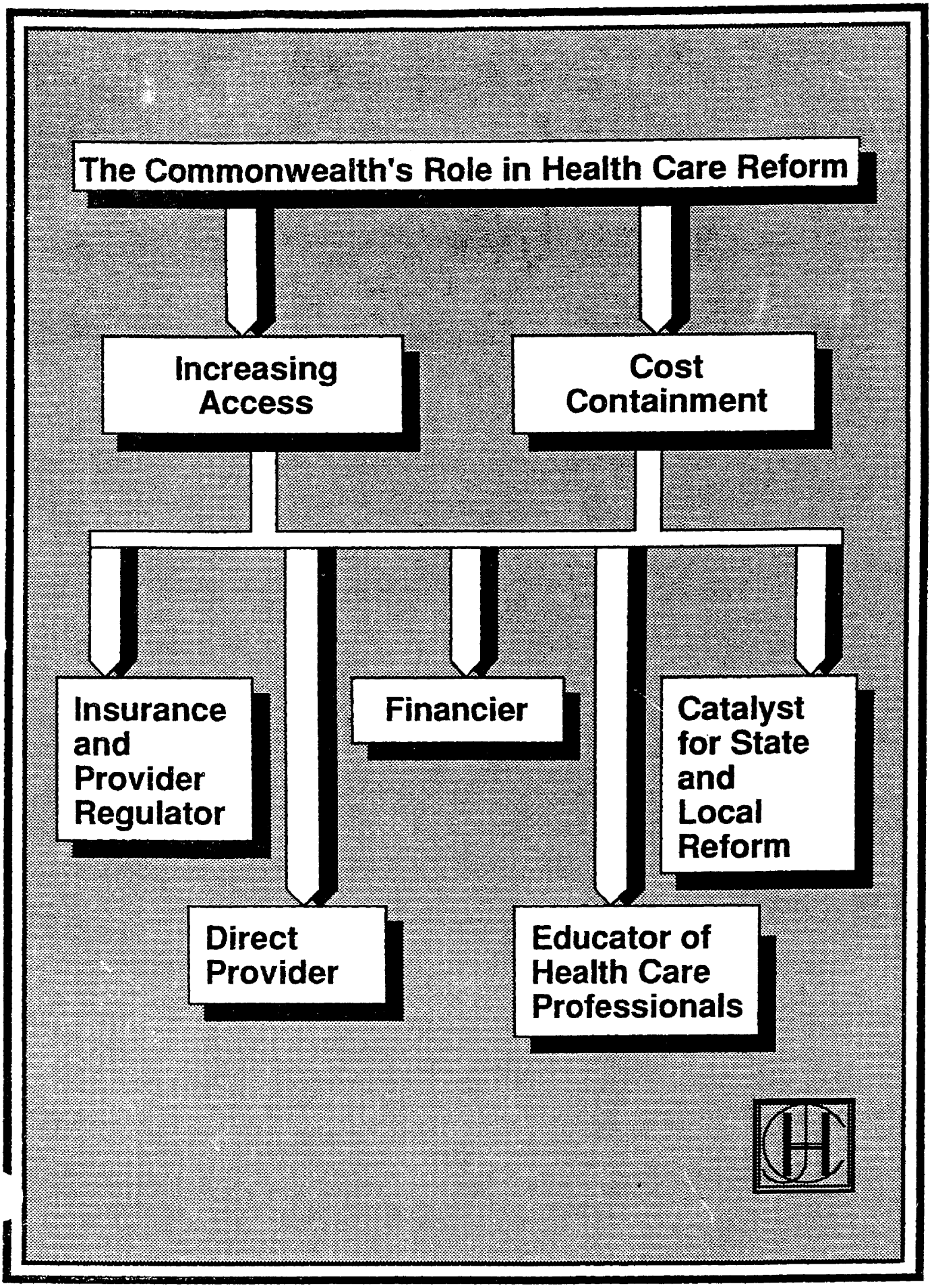


Table of Contents

Appendices:


The Commonwealth's Role in Health Care Reform
Increasing Access
Cost Containment
Insurance and Provider Regulator
Financier
Catalyst for State and Local Reform
Direct Provider
Educator of Health Care Professionals

I. EXECUTIVE SUMMARY

Authority for Study

The Joint Commission on Health Care was created by the 1992 Session of the Virginia General Assembly, pursuant to Senate Bill 501 and House Bill 1032. This sixteen-member legislative commission, with a separately staffed agency, continues the work of the Commission on Health Care for All Virginians (Senate Joint Resolution 118, 1990 Session).

1994 Commission Activities

The Joint Commission held nine meetings in 1994, as well as two additional meetings in January, 1995, prior to the 1995 Session of the General Assembly. All meetings were held at the General Assembly Building in Richmond. In addition to the agenda items identified below, monthly staff reports were presented at each meeting.

At the May 2nd meeting, the current status of Joint Commission on Health Care initiatives, as well as the status of the Joint Commission's 1994 legislation were reviewed. Additionally, the workplan for 1994 and the 1993 Annual Report were presented and reviewed.

The May 23rd meeting included an interim report on the feasibility of implementing a health insurance purchasing cooperative in Virginia. Follow-up reports on organized health services delivery systems, specifically solvency requirements for Community Health Networks, and anti-trust immunity for health care providers were presented. A case study of TENNCARE, a Medicaid capitation program in Tennessee, was also presented.

A new Chairman and Vice Chairman were elected at the June 27th meeting in accordance with a policy to rotate these positions among the House and Senate every two years. Delegate Jay W. DeBoer was elected Chairman and Senator Elliot S. Schewel was elected Vice Chairman. A summary of the

public comments received on the issues presented at the May 23rd meeting was provided. In addition, an analysis of indigent hospital care in Virginia and a case study of Maryland were presented. F. Reid Cushman, Senior Associate of the Virginia Health Policy Research Center, presented an interim report on hospitals' contribution to the community.

The August 1st meeting included reports on: (i) the impact of the "any willing provider" statute on the cost and quality of health care in Virginia; (ii) the impact of managed care practices on independent medical laboratories; (iii) the impact of defensive medicine; and (iv) the optimum use of nurse practitioners.

A summary of the public comments received on the four studies presented at the August 1st meeting was provided. John E. Jones, M.D., Vice President for Health Sciences at the Medical College of Virginia (MCV), presented a status report on the MCV Hospital Downsizing Initiative. Lastly, an overview of key health care issues was presented, including information regarding: (i) the current trends in health care financing and delivery; (ii) the major national health care reform proposals; (iii) the Commonwealth's various health care roles; and (iv) the goals for health care reform in Virginia.

At the September 26th meeting, status reports on regulations governing neo-natology units and child health initiatives were provided. In addition, a report on school-based health insurance programs was presented as well as an overview of health insurance reform issues and information regarding access to care for the uninsured.

A summary of the public comments received on the reports presented at the previous meeting was provided during the October 24th meeting. Ms. Margaret E. O'Kane, President of the National Committee for Quality Assurance (NCQA), gave an overview of the quality assurance efforts of NCQA, and suggested ways in which states can measure and improve the quality of health care plans and services. Finally, summaries of key cost and quality issues and health workforce issues also were presented.

The November 7th meeting included a presentation by Kay Coles James, Secretary of Health and Human Resources, and Robert C. Metcalf, Director of the Department of Medical Assistance Services, on the reorganization of long-term care services. Mr. Metcalf also presented a report on incentives to purchase long-term care insurance and an update on the implementation of PACE (Program of All-Inclusive Care for the Elderly) pilot programs in Virginia. Paul E. Parker, Director of the Office of

Resources Development in the Department of Health, presented a study of the moratorium on the issuance of certificates of public need for nursing home beds. Lastly, Mr. Metcalf and Carol A. Brunty, Commissioner of the Department of Social Services, presented a status report on past long-term care initiatives.

During the November 28th meeting, a summary of the public comments received on the long-term care reorganization plan was presented. In addition, Joseph M. Teefey, Deputy Director of the Department of Medical Assistance Services, and Barbara S. Brown, Director of Clinical Information Systems with the Virginia Hospital Association, presented a report on the "Medicaid Hospital Length of Stay" initiative. A summary of each issue studied by the Joint Commission during 1994, along with a recap of the options presented for addressing each issue, was provided.

A report on hospitals' contribution to the community was presented at the January 9, 1995 meeting. Recommendations regarding each of the various issues studied by the Joint Commission throughout 1994 as well as potential legislation to be introduced during the 1995 Session of the General Assembly also were presented. At the January 16, 1995 meeting, the public comments received on the hospital study were summarized. Also, final decisions regarding potential 1995 legislation were made.

Individual Study Reports Published by the Joint Commission on Health Care

The Joint Commission conducted numerous studies throughout 1994. In past years, the Joint Commission incorporated the written reports from each study into the annual report. However, in 1994, the Joint Commission prepared a separate report on each study that was conducted pursuant to a study resolution. These reports, called "issue briefs," were presented to the Joint Commission at its monthly meetings.

Copies of each issue brief were distributed to persons attending the meeting at which the study was presented to the Joint Commission, as well as other interested parties who requested a copy. Public comments were received on each issue brief and presented to the Joint Commission at the next monthly meeting. Following the public comment period, each issue brief was finalized and printed as either a House or Senate Document. Figure 1 identifies each of the Joint Commission's studies which were printed as separate documents.

Figure 1

Individual Study Reports Published by the Joint Commission on Health Care

Name of Study	House/Senate Joint Resolution	House/Senate Document
Health Insurance Purchasing Cooperatives	SJR 132	Senate Document 21
Community Health Networks	SJR 126	Senate Document 22
"Any Willing Provider" Statute	SJR 158	Senate Document 23
Impact of Defensive Medicine	SJR 159	Senate Document 24
Optimum Use of Nurse Practitioners	SJR 164	Senate Document 25
Hospitals' Contribution to the Community	SJR 110	Not Yet Submitted
School-Based Health Insurance	HJR 191	House Document 19
Impact of Managed Care on Medical Laboratories	HJR 233	House Document 20
Access to Health Care for Uninsured Children	HJR 183	House Document 32

NOTE: All joint resolution numbers are from the 1994 General Assembly Session. All House/Senate Document numbers are 1995 document numbers.

1995 Legislative Proposals

As a result of the work completed by the Joint Commission during 1994, a series of legislative proposals was introduced during the 1995 Session of the General Assembly. The following paragraphs identify each legislative proposal. For each legislative proposal, the parenthetical expression indicates the 1995 General Assembly's actions on the recommendation. A copy of each bill and resolution approved by the General Assembly is provided in Appendix A.

Health Workforce

Proposed Legislation

1. Legislation (SB 890) to allow local health departments to accept donations to support Virginia Health Care Foundation projects.

   (Legislation approved by General Assembly.)

2. Legislation (SB 984) which increases the supervisory ratio for prescriptive authority for nurse practitioners in private practice settings from 1:2 to 1:4.

   (Legislation approved by General Assembly.)

3. A joint study resolution (SJR 308) requesting the Joint Commission on Health Care to evaluate the need and effectiveness of each health workforce program.

   (Resolution adopted by General Assembly.)

4. A joint study resolution (HJR 512) requesting Virginia's Academic Health Centers, in cooperation with the Area Health Education Centers Program, to develop collaborative training models for physicians and nurse practitioners.

   (Resolution adopted by General Assembly.)

5. A joint resolution (HJR 558) commending Virginia's private sector contributors to the Virginia Health Care Foundation, and encouraging other corporate citizens to support the Foundation.

   (Resolution adopted by General Assembly.)

Budget Amendments

1. Language and budget amendments ($1,858,213 in general funds for FY 1996) for the three medical schools in Virginia (the University of Virginia, Virginia Commonwealth University/Medical College of Virginia, and the Medical College of Hampton Roads) and the Virginia Statewide Area Health Education Centers Program to support the Generalist Physicians Initiative. The Generalist Initiative seeks to

increase the number of medical school graduates entering generalist physician practices.

Associated language amendments direct the schools to set a goal of increasing the proportion of generalist graduates who eventually practice in Virginia. Also, language directs Virginia Commonwealth University and the University of Virginia to expand generalist training programs in southwest Virginia.

($1,333,049 in general funds approved for FY 1996; language amendments approved.)

Note: *the funding for FY 1996 represents an increase above the existing appropriation of $1 million.*

2. Budget amendment ($85,000 in general funds for FY 1996) to increase the amount of each of the ten existing dental scholarships.

   (No additional appropriation provided for FY 1996.)

3. Budget amendment ($10,000 in general funds for FY 1996) to increase the amount of each of the five existing nurse practitioner scholarships.

   (No additional appropriation provided for FY 1996.)

Health Insurance/Access to the Uninsured

Proposed Legislation

1. Legislation (HB 1969) which would amend Virginia's "any willing provider" statute such that insurers and non-stock corporations would be required to: (i) disclose preferred provider organization (PPO) network terms and conditions; (ii) provide public notice of the development of PPO networks; (iii) accept and review all provider applications according to established terms and conditions; (iv) provide written notification of participation decisions, including reasons for denial, if applicable; and (iv) provide an internal appeals process for providers not accepted into the network.

   (No action taken by General Assembly.)

2. Legislation (HB 2043) which enacts two individual health insurance reforms: (i) prohibits individual accident and sickness insurance policies, contracts or plans from containing a pre-existing conditions provision that limits coverage beyond a 12-month waiting period; and (ii) requires insurers, HMOs, and non-stock corporations to provide credit for waiting periods for pre-existing conditions served in previous individual or group coverage.

   (Legislation approved by General Assembly.)

3. Legislation (HB 2260) which authorizes local governments to make voluntary appropriations of funds or property to the Indigent Health Care Trust Fund, and allows the Indigent Health Care Trust Fund to accept voluntary donations from local governments.

   (Legislation approved by General Assembly.)

4. A joint study resolution (SJR 316) requesting the Technical Advisory Panel of the Indigent Health Care Trust Fund to continue its efforts to convert the Trust Fund into a program to increase the number of Virginians with health insurance.

   (Resolution adopted by General Assembly.)

5. A joint study resolution (SJR 332) requesting the State Corporation Commission's Bureau of Insurance to examine individual and conversion health care coverage and market reforms.

   (Resolution adopted by General Assembly.)

Health Care Cost and Quality

Proposed Legislation

1. A joint study resolution (HJR 513) directing the Joint Commission on Health Care to study the organization and effectiveness of Virginia's health care cost and quality initiatives, including the Virginia Health Services Cost Review Council's hospital and nursing home efficiency and productivity methodology and the patient level data base system.

   (Resolution adopted by General Assembly.)

Status of Past Initiatives

Since its inception, the Joint Commission on Health Care has implemented or coordinated the implementation of numerous health care reform initiatives. In addition, other health care initiatives related to the work of the Joint Commission have been instituted. Each year, a report on the status of these initiatives is presented to the Joint Commission. The most recent status report, which was completed in April, 1995, is provided in Appendix B.

II. HEALTH CARE ISSUES FACING VIRGINIA AND THE NATION

During 1994 health care reform remained one of the most vexing issues before the nation. The hopes for comprehensive national health care reform planted in 1993 wilted during 1994 as Congress and the President failed to reach agreement on the fundamental issues of universal access, cost containment, and the role of government in our health care system. This left the states to continue their pursuit of health care reform on their own, which they did with uneven results. In the meantime, the health care market changed dramatically, creating a new array of challenges and opportunities.

Nevertheless, Virginia saw measurable improvement in its health care system during 1994. Nationally, health care costs rose at the lowest rates in years. Within the state, the proportion of Virginians without health coverage declined. At the same time, providers and health plans continued to improve their systems for assuring quality in response to demands for reform.

Even with this progress, the outlook for the future is one of concern. While health care cost inflation has slowed, it continues to outstrip the inflation rate and drive up the state health care budget. There are still more than 900,000 Virginians without health coverage, and the continued erosion of employer-based insurance places more people at risk for losing coverage. Problems of primary care under capacity still persist in inner-city and rural areas. Our ability to evaluate the cost and quality of the health care system, while improved, is still inadequate to support an efficient health care market. Finally, the cost and quality of long-term care continues to loom as a growing problem.

These problems, while not unique to Virginia, will require uniquely Virginian solutions. The prospects for comprehensive national health care reform are dim, and there are no reform models from other states which would immediately fit the needs of Virginia. This chapter describes the changing health care market and the status of health care costs, quality

and access in the Commonwealth in an effort to set the stage for further progress in 1995.

THE CHANGING HEALTH CARE MARKET

Although federal and state policies may have a profound impact on the future of our health care system, it is important to recognize that the health care market in Virginia is rapidly reforming itself. Managed care is emerging as the preferred mode of service delivery as purchasers are demanding both cost containment and greater accountability from health plans and providers. As a result, new relationships are developing amongst providers and health plans as they try to position themselves for the managed care market. This trend is placing additional strain on some providers, particularly large teaching institutions and solo and small group providers who are not affiliated with a managed care organization.

Managed Care Is Becoming The Preferred Mode Of Service Delivery

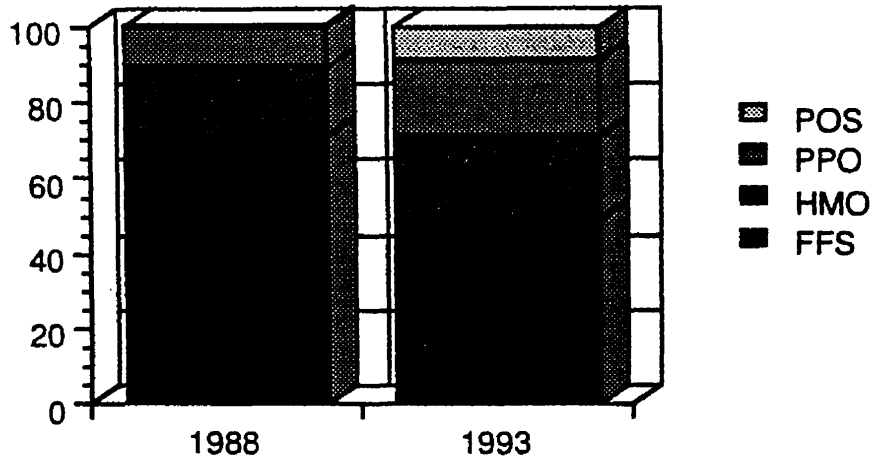
The traditional health care system has focused on the control or cure of illness. Under this system, patients typically do not seek out care until they are ill, and the value of the care they receive depends on the efficacy of a particular treatment for the illness at hand. Payment is typically made on a fee-for-service basis, so that the financial incentive is for individual providers to maximize the volume or intensity of the care they deliver. The incentive for payers is to micro-manage health care decisions through utilization review programs.

By contrast, the evolving health care system is focused on managing the health of the patient in addition to dealing with illness. Primary and preventive care are stressed in an effort to avoid illness or at least detect illness in its early stages. When medical care is needed, primary care physicians play a key role guiding the patient through a cooperative system of providers and facilities. Under the evolving system, payment is increasingly made on the basis of full or partial "capitation," or a fixed price per covered life. This approach gives providers an additional incentive to keep patients healthy.

This shift in the health care delivery paradigm is reflected in the dramatic growth in managed health care. As of 1988, 71 percent of Americans with health coverage participated in a traditional fee-for-service health plan, while only 29 percent participated in a managed care plan. Of those in managed care, 18 percent had health maintenance organization (HMO)

coverage and another 11 percent had preferred provider organization (PPO) coverage.

Market Shares of Health Plan Types

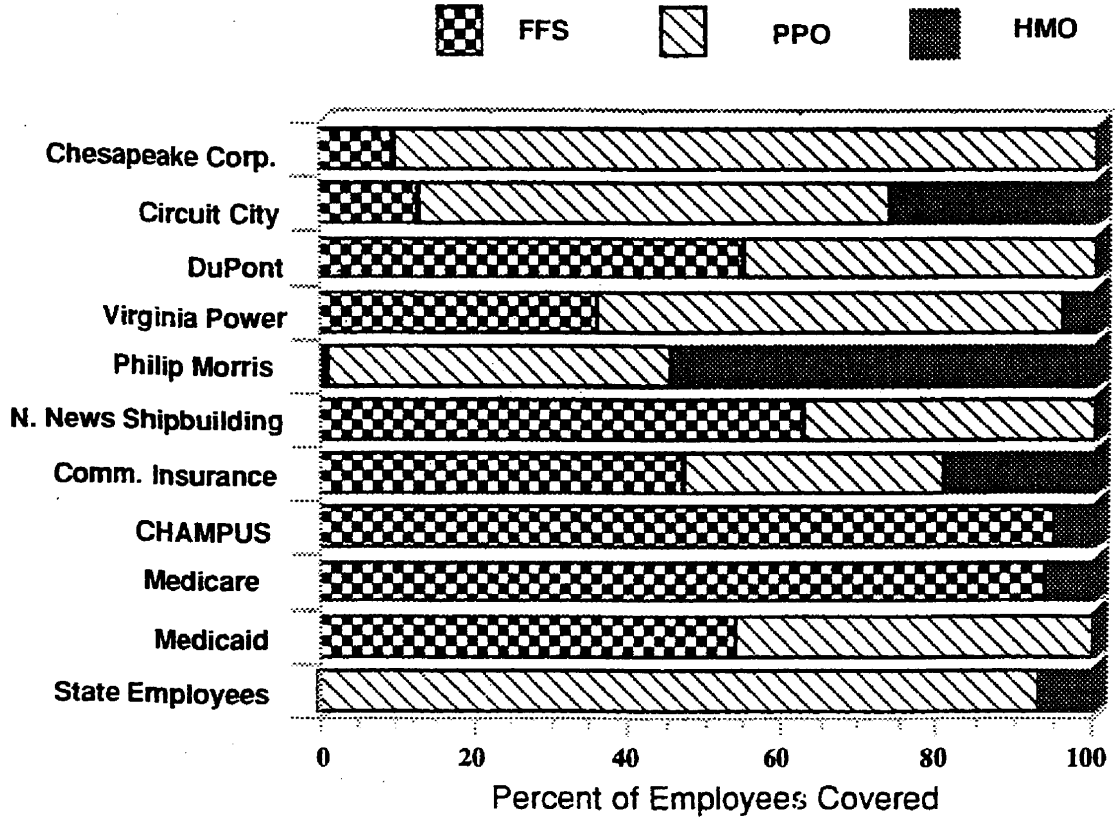


Source: Lynn Etheridge, Consultant, 1994

By 1993, less than half of those with health coverage had a traditional fee-for-service health plan. Twenty-two percent had HMO coverage, and 11 percent had PPO coverage. In addition, 9 percent had point-of-service (POS) coverage. POS coverage typically gives the client traditional HMO coverage with an option to purchase care from outside the HMO for an additional cost.

These national trends have taken hold in Virginia. Virginia's largest private employers cover large numbers of employees in managed care plans. The State Employee Health Benefits Plan is entirely managed care, with most employees choosing PPO coverage and some choosing HMO coverage (where it is available). Virginia Medicaid has placed many of its recipients in the Medallion managed care program, and plans to significantly expand its use of managed care over the coming year. Two major federal programs, Medicare and CHAMPUS, make comparatively little use of managed care, although managed care options are being examined for these programs.

Employee Health Coverage for Major Virginia Employers and Government Programs 1994



Providers And Insurers Continue To Diversify And Integrate

The demand for managed care has fueled major shifts in the health care marketplace. Physicians, hospitals, other providers, and in some cases insurers are forming new alliances to position themselves as competitive managed care providers. A growing number of Virginia hospitals are part of a larger system, and many more are exploring the options. At the next level of organization, hospitals and physician group practices are joining forces to offer a range of physician and hospital services to self-insured firms and health plans. In addition, some of these physician-hospital organizations are exploring the possibility of forming an HMO or other health plan, if they have not already done so.

It is no surprise that these developments have caused turmoil in the marketplace. Many solo and small-group providers who are not already affiliated with a managed care plan are afraid that they might not be included in the evolving system of managed care networks. Large teaching hospitals also feel at risk because their teaching costs make it difficult for them to compete on price in the managed care marketplace. There is also a concern among consumers that the financial incentives of managed care might lead health plans and providers to relax quality standards. Nevertheless, most observers would agree that managed care has arrived as the predominant mode of service delivery, and the essential issue is to make sure that managed care plans are accountable for both quality and cost.

HEALTH CARE ACCESS, COSTS, AND QUALITY

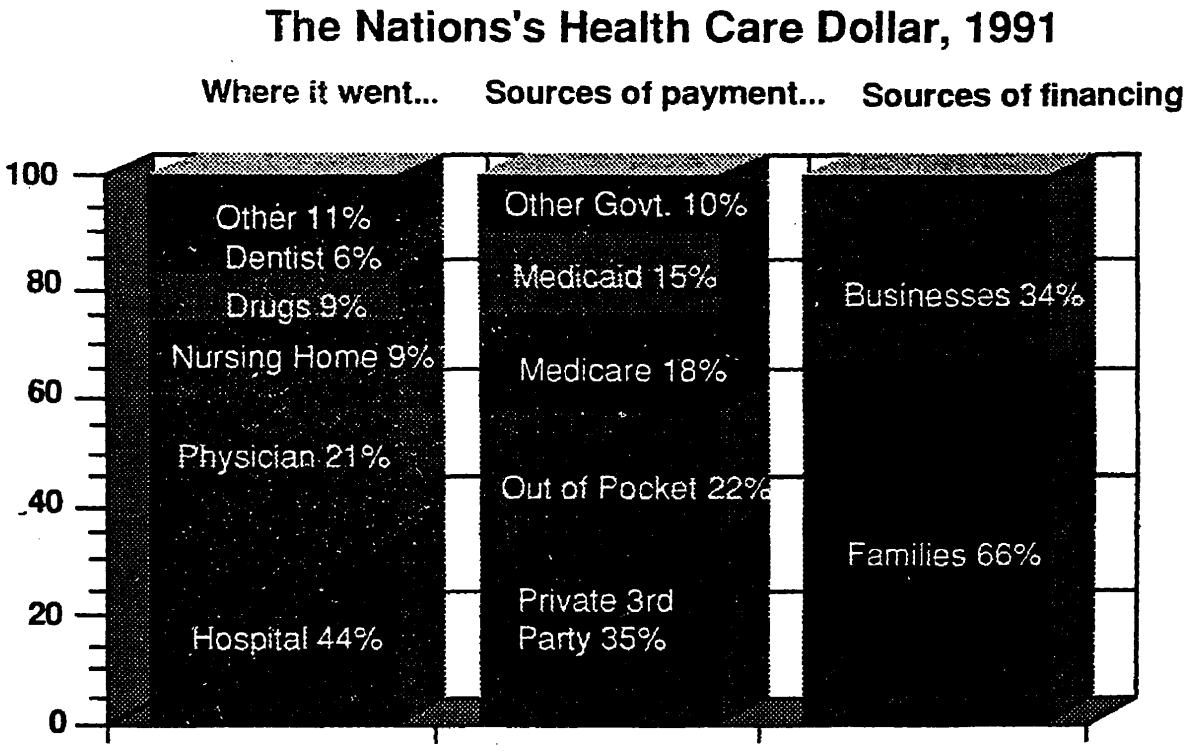
While there have been dramatic changes in the health care market, major concerns still remain. Health care spending is a continuing concern for individuals, families, businesses, and governments alike. For effective market reform to continue, consumers will need much better information on the cost and quality of health plans and providers. Too many Virginians still lack health insurance, and even those with coverage are not guaranteed access to needed services. In addition, major changes will be needed if Virginians are to have access to affordable, high-quality long-term care into the next century.

Health Care Spending Is A Continuing Concern Despite Recent Declines In Health Care Cost Inflation

Spiraling costs continue to be a major concern within our health care system and a primary driver of reform initiatives. According to the Congressional Budget Office, national health expenditures are expected to exceed $1 trillion in 1995 and $2 trillion by the year 2003. Health expenditures currently account for about 15 percent of gross domestic product (GDP), and are expected to reach 20 percent of GDP by the year 2000. National health expenditures include all types of spending for health care, including services and research.

Most of our expenditures for health services are spent on hospital and physician care. As of 1991, a surprisingly large share of those payments -- 43 cents of every dollar -- came from a government program. Another 35 percent came from private third-party payers, and about 22 percent came from out-of-pocket payments. Individuals and families paid for about

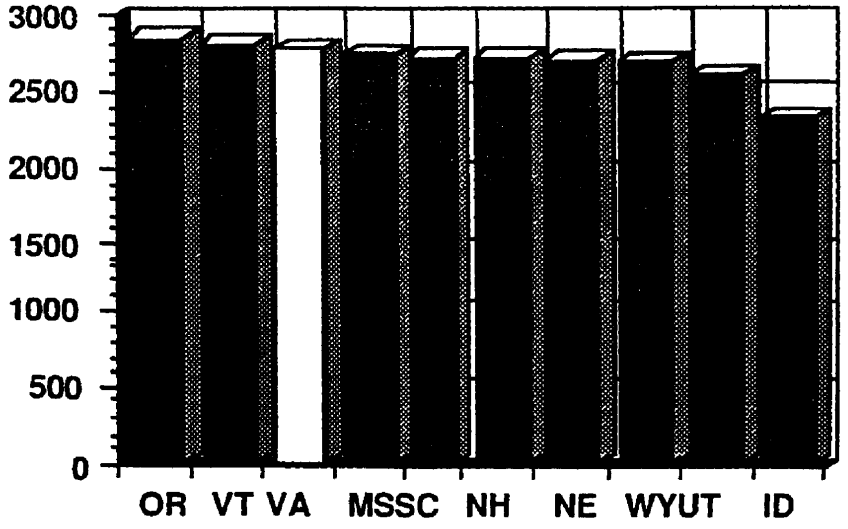
two-thirds of our national health bill, with businesses paying for the remaining one-third.



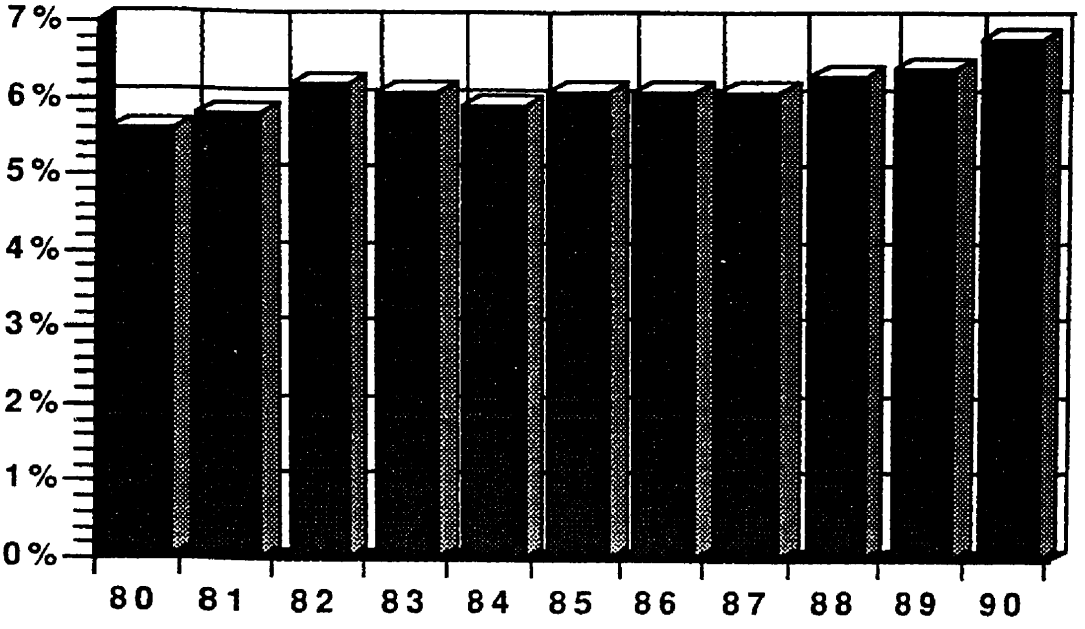
Source: U.S. Health Care Financing Administration, Lewin-VHI, Inc.

Health care spending varies widely across the country, and Virginia health expenditures are relatively low compared to the other states. In 1993 Virginia ranked among the bottom ten states in both per capita health expenditures and health expenditures as a percent of gross state product. However, at least through 1990, the proportion of Virginia's gross state product devoted to health care has been growing. On a per capita basis, in 1980 Virginia spent about 5.6 percent of its gross state product on hospital, physician, and prescription drug services, compared to 6.8 percent in 1990.

Bottom Ten States in Per Capita Health Expenditures
1993



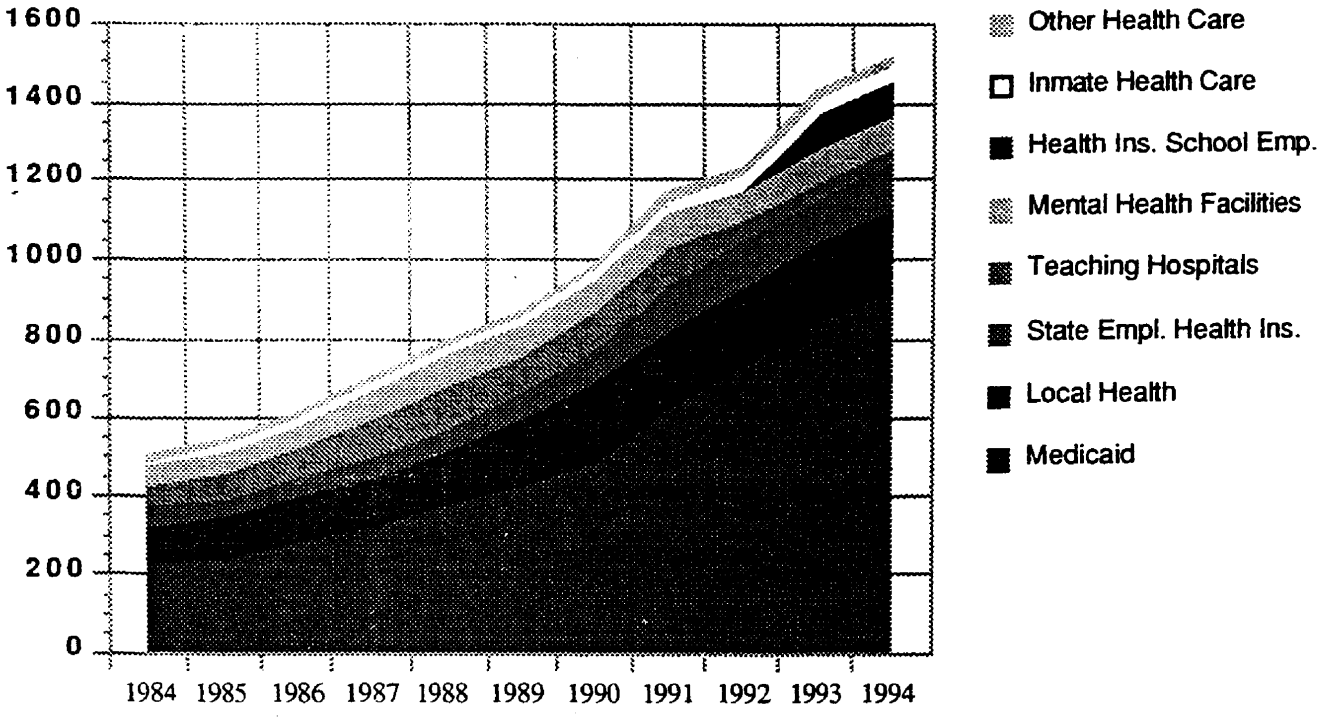
Virginia Health Expenditures
As Percent of Gross State Product
1980-1990



Source: Lewin-VHI, 1994. *Health Care Problems: Variation Across the States.* Prepared for the National Institute for Health Care Management.

Virginia State Government Health Expenditures 1984-1994

GF Dollars in Millions



Source: Department of Planning & Budget

As a purchaser and provider of health care services, Virginia state government has carried the burden of health care cost inflation. Virginia state government health expenditures reached $1.5 billion in FY 1994, and tripled between FY 1984 and FY 1994. As health care spending has continued to increase at a higher rate than the overall budget, Virginia has had to devote an increasing share of its budget to health services. In FY 1994 Virginia spent approximately 22 percent of its general fund budget on health care services, compared to 15 percent in FY 1986.

These trends in national and state health expenditures have been driven by changes in prices, individual demands for services, and population growth. Recently, much attention has been given to the fact that medical price inflation has actually begun to slow in recent years, declining from 8.5 percent in 1990 to less than six percent in 1993. In a related trend, the growth in health insurance premiums has also slowed over this same period.

While these statistics are positive signs, they should be viewed with caution. It is important to recognize that inflation in medical prices and insurance premiums still outstripped general inflation by significant margins. New technologies continue to fuel price inflation as well as the demand for additional medical services. Population growth, and particularly the emerging growth in the elderly population, will place unprecedented strains on our health care system for years to come. In the absence of continued reform, health expenditures will continue to consume an increasing share of our national, state, business, and family budgets.

Consumers Need Better Information on Health Care Cost and Quality

While it is instructive to track the broad cost trends outlined in this chapter, it is important to recognize that effective market-driven reform can only be accomplished if consumers are able to use cost information in their day-to-day purchasing decisions. One of the most persistent weaknesses in our health care system is the lack of information on the comparative cost and quality of individual health plans and providers. Cost and quality information is critical to the proper functioning of the health care market so that those organizations providing the best services will be able to attract the most customers. The demand for performance information intensified during 1994 as purchasers of managed care plans wanted to be assured that quality would not be sacrificed to economic efficiency.

One response to these demands is heightened interest in HMO accreditation by the National Commission for Quality Assessment (NCQA). To date, NCQA has conducted accreditation reviews on more than 160 HMOs across the country, including three in Virginia, and three more are pending. Across the country, many payers require NCQA accreditation as a criterion for offering HMO coverage to employees or Medicaid recipients. In another important development, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now publishes report cards on the

accreditation of hospitals and other healthcare organizations under its organizational umbrella.

The Commonwealth took two important steps along the road to building better accountability systems during 1994. In December, the Virginia Health Services Cost Review Council released its first set of hospital and nursing home efficiency and productivity indicators under a revised assessment methodology. Also, the hospital industry and Virginia Health Information, Inc. worked together to collect the first year's worth of inpatient data for the Virginia patient level data base. These initiatives marked the first phase of a process which will eventually lead to the development of quality indicators for Virginia's health care institutions.

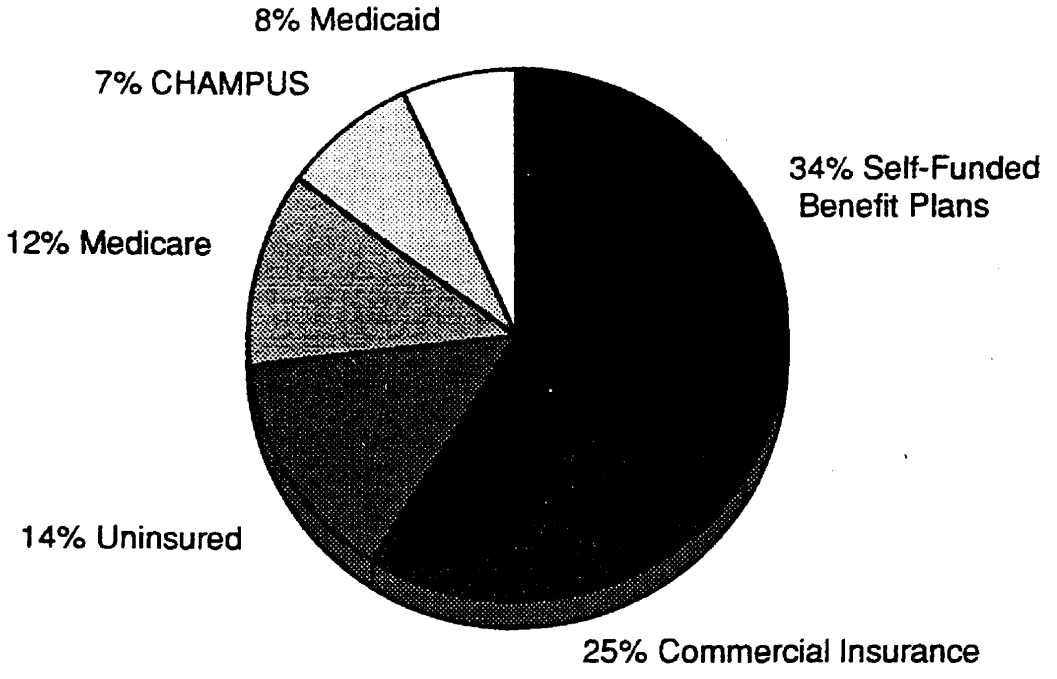
It is important to recognize that external demands for accountability have helped stimulate major initiatives in internal quality control among health care providers. More and more provider organizations are conducting research on the most cost-effective treatments for various medical problems. In addition, many Virginia hospitals have developed Continuous Quality Improvement (CQI) programs designed to improve the cost-effectiveness of a wide range of clinical and administrative services. Many of these same hospitals are actively restructuring by reducing unneeded inpatient services and expanding outpatient services.

While substantial progress has been made toward accountability, most Virginians remain ill-equipped to compare their options of health plans and providers on the basis of cost and quality. The development of useful cost and quality information, and the role of the state in producing and using this information, are two of the most important questions on the health care reform agenda.

Access To Health Insurance Is A Continuing Problem Amidst Some Signs of Progress

The surest way for a person to obtain high quality health care services is to obtain health coverage through private or public insurance. As of 1993, an estimated 14 percent, or one in seven Virginians, was without health coverage. Among those with health coverage, about sixty percent of all Virginians were covered through self-funded benefit plans or commercial insurance plans. Government-sponsored programs covered another 25 percent of Virginians, with the remainder being uninsured.

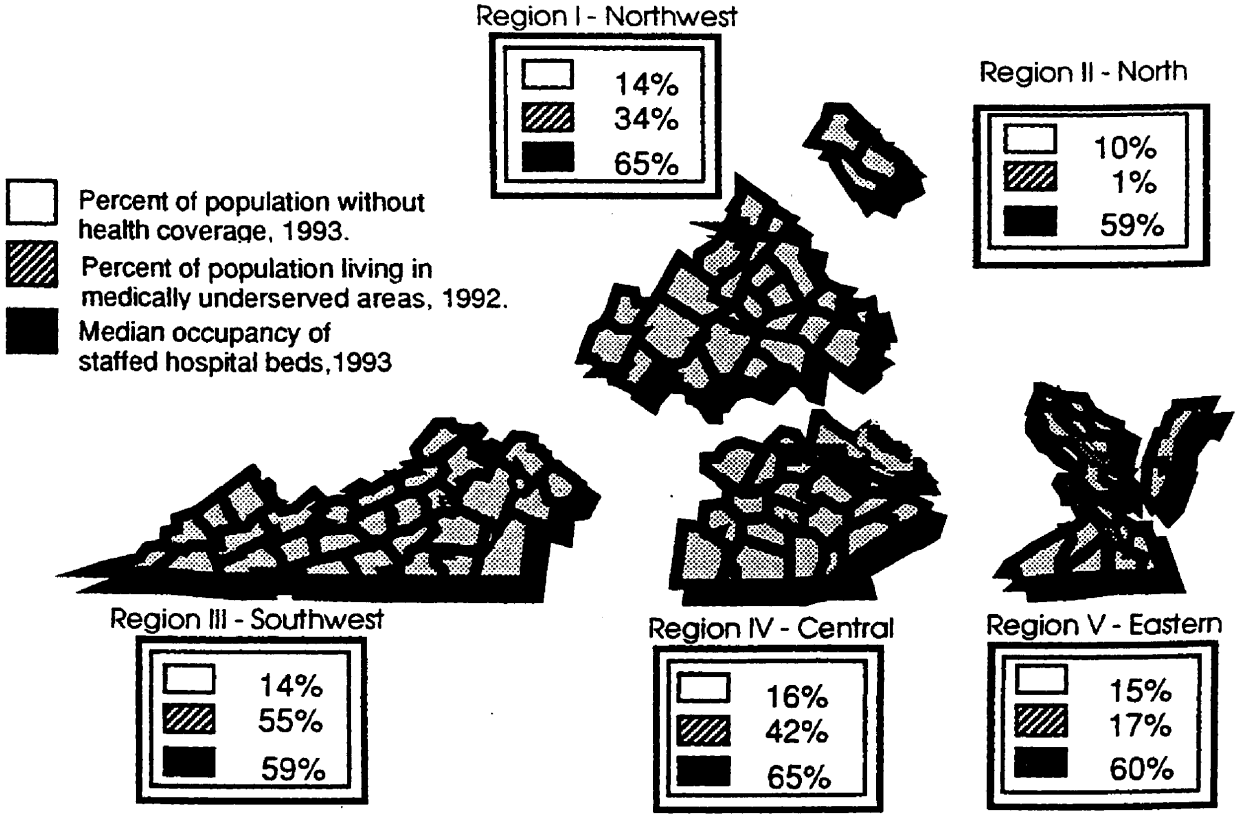
Health Insurance Status of Virginians
1993



Source: Virginia Commonwealth University Survey Research Laboratory, U.S. Health Care Financing Adminsitration, CHAMPUS staff, Joint Commission on Health Care staff.

A 1993 survey by Virginia Commonwealth University showed that lack of insurance is a statewide problem. Northwest, Southwest, Central, and Eastern Virginia all have uninsurance rates of at least 14 percent, while the uninsurance rate in Northern Virginia is approximately 10 percent. It is important to recognize that even among the insured, the level of coverage varies. The survey found that people in Southwest and Central Virginia with coverage were less likely than those in other regions to be covered by a comprehensive policy.

Key Indicators of Health Care Access and Utilization in Virginia

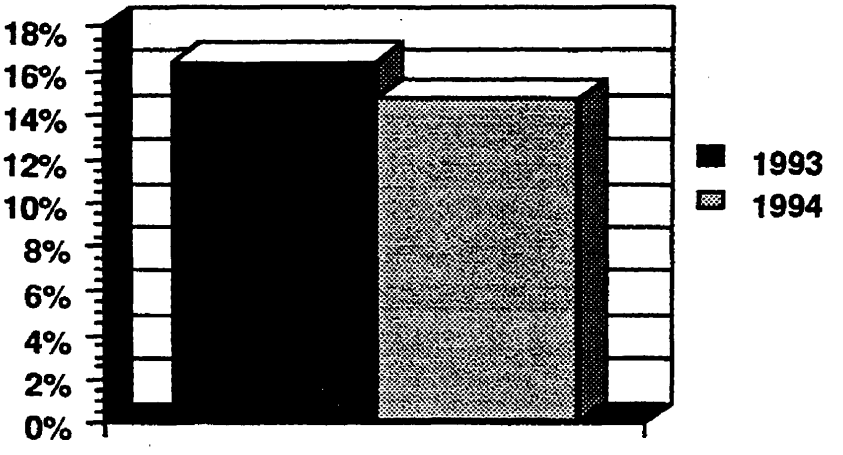


Source: VCU Survey Research Laboratory, Virginia Department of Health, Virginia Health Services Cost Review Council.

Lack of health coverage affects a broad range of Virginians. The VCU survey showed that one out of four uninsured people was a child. Most uninsured adults worked either full-time or part-time, although significant numbers were either unemployed (14 percent), homemakers (13 percent), or retired (9 percent). Many of the uninsured were from poor or low income households, with more than half living in households with income of $20,000 per year or less. Six out of ten uninsured were white, three out of ten were black, and one out of ten was of another minority race.

There is recent evidence that access to health coverage in Virginia improved during 1994. According to a study by the Alpha Center, a health policy research organization in Washington, D.C., Virginia was one of thirteen states which actually experienced a drop in the percentage of people uninsured between 1993 and 1994. The study, which focused on insurance rates for the non-elderly (under the assumption that virtually all of the elderly would be covered by Medicare), indicated that the percent of non-elderly uninsured in Virginia declined from 16.4 percent in 1993 to 14.8 percent in 1994. This trend reflects an increase in both private coverage and government-financed Medicaid coverage.

Percent of Non-Elderly Virginians Without Health Insurance 1993 and 1994



Source: Alpha Center, 1994.

The same study also pointed out a disturbing national trend toward declining employer-based coverage. In 1994, 900,000 fewer Americans under age 65 were covered by employer-based health plans. While nearly 3.2 million more workers reported securing health coverage through their employer, this gain was offset by a drop of 4.1 million dependents from employer-based plans. Children under 18 accounted for most of the net loss in dependent coverage. This pattern fits a trend of employers requiring workers to pay for more of the cost of dependent coverage.

Given the chronic problems in the health insurance market, insurance reform and Medicaid reform will remain among the highest priorities for health care reform.

Access to Health Insurance Does Not Assure Access to Necessary Health Services

Access to health services is profoundly affected by access to health insurance. Nearly one third of respondents to the VCU survey reported that during the preceding year, someone in their household had experienced difficulty in obtaining needed medical care because of an inability to pay for it out of pocket. Households with lower incomes were much more likely to report problems than those with higher incomes. For instance, 21 percent of respondents with comprehensive coverage reported experiencing a financial barrier to health care, compared to 69 percent of those with no coverage.

However, financing alone does not guarantee access to needed health services. In numerous medically underserved rural and inner-city communities within Virginia, there are not enough primary care providers to meet the needs of the population. Moreover, the presence of providers does not guarantee adequate access, even for those with coverage. Not all providers are willing to accept new patients, particularly patients with no coverage or low-reimbursement coverage. It can also be difficult for primary care providers to effectively manage the care of patients who have little experience with seeking appropriate preventive and primary care services.

Inadequate access to health services takes its toll in personal wellness. Research clearly indicates that the uninsured are less likely than the insured to receive needed medical services such as immunizations and routine check-ups. As a result, they are more likely to develop conditions which could have been prevented or more successfully treated with early intervention, such as low birth weight, advanced breast cancer, and uncontrolled diabetes. Too often the result is a visit to the hospital emergency room which might even lead to a hospital admission. In cases where the patient has no health coverage, the cost of this care is borne by physicians and hospitals or passed along to paying patients in the form of higher prices.

As both public and private employers adopt managed care as the preferred mode of health care delivery, there will be an even greater need for high quality primary care providers in all regions of the

Commonwealth. In most managed care models, the primary care physician is the gateway to the health care delivery system, responsible not only for delivering high quality services, but also for managing the overall care of the patient. Meeting this demand will require significant changes in the way health care providers are trained and compensated in Virginia. The evolving emphasis on primary care will also prompt hospitals to continue restructuring in the face of declining inpatient occupancy and increasing demand for primary and other ambulatory care services.

Long Term Care Is A Growing Concern

Long term care is a critical component of Virginia's health care system. Yet, long--term care cannot be addressed within the same conceptual framework as primary and acute care services because of the unique needs of long-term care clients and different nature of long-term care service delivery and financing. Those in need of long-term care are among our most vulnerable citizens, and the emotional and economic impact of long-term care on clients and their families can be devastating. Recognizing this, in 1993 the General Assembly adopted the following policy for long-term care in the Commonwealth: "to provide services to individuals with programs and in settings which maximize their ability to function as independently as possible and which encourage the principles of personal dignity, a decent quality of life, individuality, privacy, and the right to make choices."

Several trends combine to make long term care one of the most important health care reform issues in the Commonwealth. Growth in the population needing long-term care, diminishing capacity of family members to provide long-term care to family members on a full-time basis, health care cost inflation, and demographic changes which will leave fewer workers to pay for the retirement of more elderly all point to a future in which it will be difficult to maintain the current system of long-term care delivery and financing. Even today, studies have found that Virginia's long-term care system pays too little attention to individual needs, does not provide for timely intervention, fragments service delivery, and often fails to recognize the importance of family and community life.

As a result of this situation Virginia is facing a broad long term care reform agenda. Programs will have to be reorganized to become more client-focused and more devoted to providing care in the least restrictive setting closest to family and community. Financing will have to be reformed to achieve equitable cost sharing between families, insurance, and public programs. Also, long-standing barriers between the long-term

care and acute care systems will have to be removed so that long-term care clients can benefit from comprehensive, coordinated health care services.

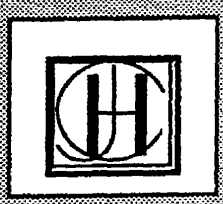
THE CHALLENGE AHEAD

This overview of health care issues facing Virginia and the nation shows that we are in the midst of dramatic change in the health care market. This change raises important public policy issues. As the market moves toward managed care and new types of delivery systems, many of our traditional providers of indigent care -- ranging from major teaching hospitals to individual physicians -- will be challenged to become more efficient and price-competitive while maintaining their commitment to providing charity care. These same pressures will make it difficult for those who teach our health professionals to maintain their commitment to both teaching and clinical service.

One of the most important questions before us is what role Virginia state government should play in solving these and other problems in our health care system. The record to date illustrates that the power for change lies neither in the market by itself nor in government by itself, but in partnership between the two. As the Joint Commission on Health Care continues its journey toward health care reform, it will need the help of all interested citizens in charting a course that fits the needs of Virginia.

APPENDIX A:

1995 Legislation (As Approved)



Joint Commission on Health Care
1995 Legislation
(As Approved)

Senate Bills	Description
SB 890	Allows Local Health Departments to Accept Donations for Virginia Health Care Foundation
SB 984	Increases Supervisory Ratio for Prescriptive Authority for Nurse Practitioners in Private Practice Settings from 1:2 to 1:4

House Bills	Description
HB 2043	Enacts Individual Insurance Reforms
HB 2260	Allows Indigent Health Care Trust Fund to Accept Donations from Local Governments

Senate Joint Resolutions	Description
SJR 308	Requests Joint Commission on Health Care to Study Organization and Effectiveness of Health Workforce Initiatives
SJR 316	Requests Technical Advisory Panel to Continue Efforts to Reconfigure Indigent Health Care Trust Fund
SJR 332	Requests Bureau of Insurance to Study Individual Insurance Reforms

House Joint Resolutions	Description
HJR 512	Requests Academic Health Centers and Area Health Education Centers Program to Develop Collaborative Training Models for Physicians and Nurse Practitioners
HJR 513	Requests Joint Commission on Health Care to Study the Organization and Effectiveness of Virginia's Health Care Cost and Quality Initiatives
HJR 558	Commends Private Contributors to the Virginia Health Care Foundation

CHAPTER 498

An Act to amend the Code of Virginia by adding in Article 5 of Chapter 1 of Title 32.1 a section numbered 32.1-34.1, relating to powers of local health departments.

[S 890]

Approved March 23, 1995

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 5 of Chapter 1 of Title 32.1 a section numbered 32.1-34.1 as follows:

§ 32.1-34.1. Power to seek and receive donations.

Any health department operating under the provisions of this article is empowered to seek and accept grants, bequests or donations of money and resources from private persons in support of projects conducted under the auspices of the Virginia Health Care Foundation or other preventive or primary health care projects. A separate fund shall be established so as to segregate the amounts appropriated and the amounts bequeathed or contributed thereto. No portion of this fund derived from private contributions or bequests and designated for support of Virginia Health Care Foundation projects shall be used for any other purpose. Any money remaining in this fund at the end of the biennium shall not revert to the general fund but shall remain in the fund described herein. Interest earned on such moneys shall remain in this fund and be credited to it. Money bequeathed or contributed to this fund shall not be used to supplant local or state appropriations.

CHAPTER 506

An Act to amend and reenact § 54.1-2957.01 of the Code of Virginia, relating to prescriptive authority of licensed nurse practitioners.

[S 984]

Approved March 23, 1995

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2957.01 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2957.01. Prescription of certain controlled substances and devices by licensed nurse practitioners.

A. A licensed nurse practitioner, other than a certified registered nurse anesthetist, shall have the authority to prescribe Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.) of this title pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.) of this title upon the provision to the Board of Medicine and the Board of Nursing of such evidence as they may jointly require that the nurse practitioner has entered into and is, at the time of writing a prescription, a party to a written agreement with a licensed physician which provides for the direction and supervision by such physician of the prescriptive practices of the nurse practitioner.

B. It shall be unlawful for a nurse practitioner to prescribe controlled substances or devices pursuant to this section unless such prescription is authorized by the written agreement between the licensed nurse practitioner and the licensed physician.

C. The Board of Nursing and the Board of Medicine, in consultation with the Board of Pharmacy, shall promulgate such regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients.

The Board of Medicine and the Board of Nursing shall be assisted in this process by an advisory committee composed of two representatives of the Board of Nursing and one nurse practitioner appointed by the Board of Nursing, and four physicians, three of whom shall be members of the Board of Medicine appointed by the Board of Medicine. The fourth physician member shall be jointly appointed by the Boards of Medicine and Nursing. Regulations promulgated pursuant to this section shall include, at a minimum, (i) the formulary of the specific Schedule VI drugs and devices that nurse practitioners are eligible to prescribe pursuant to this section to the extent, and in the manner, authorized in a written protocol between the nurse practitioner and the supervising physician, and (ii) requirements for periodic site visits by physicians who supervise and direct nurse practitioners who provide services at a location other than where the physician regularly practices.

In order to maintain a current and appropriate list of specific Schedule VI drugs and devices, the Boards of Medicine and Nursing may, from time to time, amend the Formulary required by this subsection and, as provided in § 9-6.14:4.1, shall be exempted from the Administrative Process Act (§ 9-6.14:1 et seq.) when so doing. The Boards shall, however, jointly conduct public hearings prior to making such amendments to the Formulary. Thirty days prior to conducting such hearing, the Boards shall give written notice by mail of the date, time, and place of the hearings to all currently licensed nurse practitioners and any other persons requesting to be notified of the hearings and publish notice of its intention to amend the Formulary in the Virginia Register of Regulations. Interested parties shall be given reasonable opportunity to be heard and present information prior to final adoption of any amendments. Proposed and final amendments of the list shall also be published, pursuant to § 9-6.14:22, in the Virginia Register of Regulations. Final amendments to the Formulary shall become effective upon filing with the Registrar of Regulations.

D. This section shall not limit the functions and procedures of certified registered nurse anesthetists or of any nurse practitioners which are otherwise authorized by law or regulation.

E. The following restrictions shall apply to any nurse practitioner authorized to prescribe drugs and devices pursuant to this section:

1. The nurse practitioner shall disclose to his patients the name, address and telephone number of the supervising physician, and that he is a licensed nurse practitioner.

2. Physicians, other than physicians employed by, or under contract with, local health departments,

federally funded comprehensive primary care clinics, or nonprofit health care clinics or programs to provide supervisory services, shall not supervise and direct at any one time more than ~~two~~ *four* nurse practitioners. In the case of nurse practitioners, other than certified nurse midwives, the supervising physician shall regularly practice in any location in which the nurse practitioner exercises prescriptive authority pursuant to this section. A separate office for the nurse practitioner shall not be established. In the case of certified nurse midwives, the supervising physician either shall regularly practice in the location in which the certified nurse midwife practices, or in the event that the certified nurse midwife has established a separate office, the supervising physician shall be required to make periodic site visits as required by regulations promulgated pursuant to this section.

3. Physicians employed by, or under contract with, local health departments, federally funded comprehensive primary care clinics, or nonprofit health care clinics or programs to provide supervisory services, shall not supervise and direct at any one time more than four nurse practitioners who provide services on behalf of such entities. Such physicians either shall regularly practice in such settings or shall make periodic site visits to such settings as required by regulations promulgated pursuant to this section.

F. This section shall not prohibit a licensed nurse practitioner from administering Schedule VI controlled substances in compliance with the definition of "administer" in § 54.1-3401. However, this section shall not otherwise authorize the dispensing or the sale of Schedule VI controlled substances by licensed nurse practitioners unless pursuant to the lawful order of a physician.

2. That the provisions of this act shall expire on January 1, 2000.

CHAPTER 522

An Act to amend and reenact §§ 38.2-3503, 38.2-3605, 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3514.1, relating to individual accident and sickness insurance policies; limitations on preexisting conditions provisions.

[H 2043]

Approved March 23, 1995

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3503, 38.2-3605, 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3514.1 as follows:

§ 38.2-3503. Required accident and sickness policy provisions.

Except as provided in § 38.2-3505, each individual accident and sickness insurance policy delivered or issued for delivery in this Commonwealth shall contain the provisions specified in this section using the same words which appear in this section. An insurer may substitute corresponding provisions of different wording approved by the Commission that are in each instance not less favorable in any respect to the insured or the beneficiary. These provisions shall be preceded individually by the caption "REQUIRED PROVISIONS" or by such appropriate individual or group captions or subcaptions as the Commission may approve.

1. Provision 1:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

2. Provision 2:

TIME LIMIT ON CERTAIN DEFENSES: (a) Misstatements in the application: After two years from the date of this policy, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability (as defined in the policy) that starts after the two-year period.

Provision 2 shall not be construed to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subdivisions 1, 2, 3, 4 and 5 of § 38.2-3504 in the event of misstatement with respect to age, occupation or other insurance.

Instead of Provision 2, a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (i) until at least age fifty or, (ii) for a policy issued after age forty-four, for at least five years from its date of issue, may contain the following provision, from which the clause in parentheses may be omitted at the insurer's option:

INCONTESTABLE:

(a) Misstatements in the application: After this policy has been in force for two years during the Insured's lifetime (excluding any period during which the Insured is disabled), the Company cannot contest the statements in the application.

PREEXISTING CONDITIONS:

(b) No claim for loss incurred or disability (as defined in the policy) that starts after ~~two years~~ *one year* from the date of issue of this policy will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

3. Provision 3:

GRACE PERIOD: This policy has a . . . day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following . . . days. During the grace period the policy shall continue in force.

In Provision 3 a number not less than "7" for weekly premium policies, "10" for monthly

premium policies and "31" for all other policies shall be inserted between the words "a" and "day," and between "following" and "days."

A policy that contains a cancellation provision may add, at the end of Provision 3: "subject to the right of the Company to cancel in accordance with the cancellation provision."

A policy in which the insurer reserves the right to refuse any renewal shall have, in Provision 3, the following sentence:

The grace period will not apply if, at least . . . days before the premium due date, the Company has delivered or has mailed to the Insured's last address shown in the Company's records written notice of the Company's intent not to renew this policy.

In the above sentence a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "least" and "days."

4. Provision 4:

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by the Company or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the policy. If the Company or its agent requires an application for reinstatement, the Insured will be given a conditional receipt for the premium. If the application is approved the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless the Company has previously written the Insured of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that starts more than ten days after such date. In all other respects the rights of the Insured and the Company will remain the same, subject to any provisions noted or attached to the reinstated policy. Any premiums the Company accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than sixty days prior to the date of reinstatement.

The last sentence of Provision 4 may be omitted from any policy that the Insured has the right to continue in force subject to its terms by the timely payment of premiums (i) until at least age fifty, or (ii) for a policy issued after age forty-four, for at least five years from its effective date.

5. Provision 5:

NOTICE OF CLAIM: Written notice of claim must be given within twenty days after a covered loss starts or as soon as reasonably possible. The notice can be given to the Company at . . . . . (insert the location of such office as the insurer may designate for the purpose), or to the Company's agent. Notice should include the name of the Insured, and Claimant if other than the Insured, and the policy number.

Optional paragraph: If the Insured has a disability for which benefits may be payable for at least two years, at least once in every six months after the Insured has given notice of claim, the Insured must give the Company notice that the disability has continued. The Insured need not do this if legally incapacitated. The first six months after any filing of proof by the Insured or any payment or denial of a claim by the Company will not be counted in applying this provision. If the Insured delays in giving this notice, the Insured's right to any benefits for the six months before the date the Insured gives notice will not be impaired.

6. Provision 6:

CLAIM FORMS: When the Company receives the notice of claim, it will send the Claimant forms for filing proof of loss. If these forms are not given to the Claimant within fifteen days after the giving of such notice, the Claimant shall meet the proof of loss requirements by giving the Company a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

7. Provision 7:

PROOFS OF LOSS: If the policy provides for periodic payment for a continuing loss, written proof of loss must be given the Company within ninety days after the end of each period for which the Company is liable. For any other loss, written proof must be given within ninety days after such loss. If it was not reasonably possible to give written proof in the time required, the Company shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In

any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

8. Provision 8:

TIME OF PAYMENT OF CLAIMS: After receiving written proof of loss, the Company will pay . . . . (Insert period for payment which must not be less frequently than monthly) all benefits then due for . . . . (Insert type of loss). Benefits for any other loss covered by this policy will be paid as soon as the Company receives proper written proof.

9. Provision 9:

PAYMENT OF CLAIMS: Benefits will be paid to the Insured. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured's estate. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or the Insured's estate.

Optional paragraph: If benefits are payable to the Insured's estate or a beneficiary who cannot execute a valid release, the Company can pay benefits up to $. . . . . (insert an amount which shall not exceed $2,000), to someone related to the Insured or beneficiary by blood or by marriage whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any payment made in good faith.

Optional paragraph: The Company may pay all or a portion of any indemnities provided for health care services to the health care services provider, unless the Insured directs otherwise in writing by the time proofs of loss are filed. The Company cannot require that the services be rendered by a particular health care services provider.

10. Provision 10:

PHYSICAL EXAMINATIONS AND AUTOPSY: The Company at its own expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

11. Provision 11:

LEGAL ACTIONS: No legal action may be brought to recover on this policy within sixty days after written proof of loss has been given as required by this policy. No legal action may be brought after three years from the time written proof of loss is required to be given.

12. Provision 12:

CHANGE OF BENEFICIARY: The Insured can change the beneficiary at any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

§ 38.2-3514.1. Preexisting conditions provisions.

A. In determining whether a preexisting conditions provision applies to an insured, all coverage shall credit the time the person was covered under previous individual or group policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such coverage.

B. As used herein, a "preexisting conditions provision" means a policy provision that limits, denies, or excludes coverage for charges or expenses incurred during a twelve-month period following the insured's effective date of coverage, for a condition that, during a twelve-month period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received within twelve months immediately preceding the effective date of coverage or as to pregnancy existing on the effective date of coverage.

C. This section shall not apply to the following insurance policies or contracts:

1. Short-term travel;

2. Accident-only;

3. Limited or specified disease contracts;

4. Long-term care insurance;

5. Short-term nonrenewable policies or contracts of not more than six months' duration which are subject to no medical underwriting or minimal underwriting;

6. Individual open enrollment policies or contracts issued pursuant to § 38.2-4216.1 to persons

who were previously covered under a group health insurance policy or contract issued by another unaffiliated insurer, health services plan or health maintenance organization, and who, due to health status, are eligible for individual coverage only under §§ 38.2-3416 and 38.2-4216.1; and

7. Policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal government plans.

§ 38.2-3605. Coverage of preexisting conditions; Medicare supplement policies.

Notwithstanding subdivision 2 (b) of § 38.2-3503 *or the provisions of § 38.2-3514.1*, an insurer that issues a Medicare supplement policy shall not deny a claim for losses incurred more than six months from the effective date of coverage on the grounds that a condition existed prior to the effective date of coverage regardless of the application form used. Except as so provided, the policy or contract shall not include wording that would permit a defense based upon preexisting conditions.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3425 through 38.2-3429, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, *38.2-3514.1*, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§ 38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1310, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3500, *38.2-3514.1*, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

CHAPTER 333

An Act to amend and reenact §§ 15.1-24, 32.1-332, 32.1-333, 32.1-334, 32.1-335, 32.1-337, and 32.1-338 of the Code of Virginia, relating to the Virginia Indigent Health Care Trust Fund.

[H 2260]

Approved March 16, 1995

Be it enacted by the General Assembly of Virginia:

1. That §§ 15.1-24, 32.1-332, 32.1-333, 32.1-334, 32.1-335, 32.1-337, and 32.1-338 of the Code of Virginia are amended and reenacted as follows:

§ 15.1-24. Donations to the Virginia Indigent Health Care Trust Fund, charitable institutions and associations.

Counties, cities and towns of this Commonwealth are authorized to make appropriations of public funds, of personal property or of any real estate to *the Virginia Indigent Health Care Trust Fund and to* any charitable institution or association, located within their respective limits or outside their limits if such institution or association provides services to residents of the locality; ~~provided,~~ *however,* such institution or association ~~is~~ *shall* not *be* controlled in whole or in part by any church or sectarian society. The words "sectarian society" shall not be construed to mean a nondenominational Young Men's Christian Association or a nondenominational Young Women's Christian Association. Nothing in this section shall be construed to prohibit any county or city from making contracts with any sectarian institution for the care of indigent, sick or injured persons.

Nothing in this section shall be construed to obligate any local governing body to appropriate funds to any entity, including the Virginia Indigent Health Care Trust Fund. Any such charitable contributions shall be voluntary.

§ 32.1-332. Definitions.

As used in this chapter unless the context requires a different meaning:

"Board" means the Board of Medical Assistance Services.

"Charity care" means hospital care for which no payment is received and which is provided to any person whose gross annual family income is equal to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations.

"The Fund" means the Virginia Indigent Health Care Trust Fund created by this chapter.

"Hospital" means any acute care hospital which is required to be licensed as a hospital pursuant to Chapter 5 (§ 32.1-123 et seq.) of this title.

"Panel" means the Technical Advisory Panel appointed pursuant to the provisions of this chapter.

"Pilot health care project" means any arrangement for purchasing or providing health care, including, but not limited to, any accident and sickness insurance, health services plan, or health care plan.

"Voluntary contributions or donations" means any money voluntarily contributed or donated to the fund by hospitals or other private *or public* sources, *including local governments,* for the purpose of subsidizing pilot health care projects for the uninsured.

§ 32.1-333. Creation of fund; administration.

A. There is hereby created the Virginia Indigent Health Care Trust Fund whose purpose is to receive moneys appropriated by the Commonwealth and contributions from certain hospitals and others for the purpose of distributing these moneys to certain hospitals subject to restrictions as provided in this chapter.

B. The fund shall be the responsibility of the Board and Department of Medical Assistance Services and shall be maintained and administered separately from any other program or fund of the Board and Department. However, all funds voluntarily contributed or donated to the fund for the purpose of subsidizing pilot health care projects for the uninsured, *including any funds voluntarily contributed by local governments,* shall be administered by the Technical Advisory Panel in accordance with Board regulations.

C. The Board may promulgate rules and regulations pursuant to the Administrative Process Act (§ 9-6.14:1 et seq.) for the administration of the fund consistent with this chapter, including but not

limited to:

1. Uniform eligibility criteria to define those medically indigent persons whose care shall qualify a hospital for reimbursement from the fund. Such criteria shall define medically indigent persons as only those individuals whose gross family income is equal to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations.

2. Hospital inpatient and outpatient medical services qualifying for reimbursement from the fund. Such medical services shall be limited to those categories of inpatient and outpatient hospital services covered under the Medical Assistance Program, but shall exclude any durational or newborn infant service limitations.

3. A mechanism to ensure that hospitals are compensated from the fund only for charity care as defined in this chapter.

4. Terms, conditions, and reporting requirements for hospitals participating in the fund.

5. Terms, conditions, and reporting requirements for pilot health care projects for the uninsured.

§ 32.1-334. Fund contributions.

The fund shall be comprised of such moneys as may be appropriated by the General Assembly for the purposes of the fund and by contributions from hospitals made in accordance with the provisions of this chapter. The fund may also receive voluntary contributions from hospitals and other entities, *including local governments,* as specified by law.

§ 32.1-335. Technical Advisory Panel.

The Board shall annually appoint a Technical Advisory Panel whose duties shall include recommending to the Board (i) policy and procedures for administration of the fund, (ii) methodology relating to creation of charity care standards, eligibility and service verification, and (iii) contribution rates and distribution of payments. The Panel shall also advise the Board on any matters relating to the governance or administration of the fund as may from time to time be appropriate and on the establishment of pilot health care projects for the uninsured. In addition to these duties, the Panel shall, in accordance with Board regulations, establish pilot health care projects for the uninsured and shall administer any money voluntarily contributed or donated to the fund by private *or public* sources, *including local governments,* for the purpose of subsidizing pilot health care projects for the uninsured.

The Panel shall consist of fifteen members as follows: the Chairman of the Board, the Director of the Department of Medical Assistance Services, the Executive Director of the Virginia Health Services Cost Review Council, the Commissioner of the Bureau of Insurance or his designee, the chairman of the Virginia Health Care Foundation or his designee, two additional members of the Board, one of whom shall be the representative of the hospital industry, and two chief executive officers of hospitals as nominated by the Virginia Hospital Association.

In addition, there shall be three representatives of private enterprise, who shall be executives serving in business or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the business and industry community in Virginia including, but not limited to, the Virginia Manufacturers Association, the Virginia Chamber of Commerce, the Virginia Retail Merchants Association, and the Virginia Small Business Advisory Board. There shall be two representatives from the insurance industry who shall be executives serving in insurance companies or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the insurance industry in Virginia including, but not limited to, Blue Cross/Blue Shield of Virginia, Health Insurance Association of America and the Virginia Association of Health Maintenance Organizations. There shall be one physician member. Nominations for this appointment may be submitted to the Board by associations representing medical professionals, including, but not limited to, the Medical Society of Virginia and the Old Dominion Medical Society.

§ 32.1-337. Hospital contributions; calculations.

Hospitals shall make contributions to the fund in accordance with the following:

A. A charity care standard shall be established annually as follows: For each hospital, a percentage shall be calculated of which the numerator shall be the charity care charges and the denominator shall be the gross patient revenues as reported by that hospital. This percentage shall be the charity care percent. The median of the percentages of all such hospitals shall be the standard.

B. Based upon the general fund appropriation to the fund and the contribution, a disproportionate share level shall be established as a percentage above the standard not to exceed three percent above the standard.

C. The cost of charity care shall be each hospital's charity care charges multiplied by each hospital's cost-to-charge ratio as determined in accordance with the Medicare cost finding principles. For those hospitals whose mean Medicare patient days are greater than two standard deviations below the Medicare statewide mean, the hospital's individual cost-to-charge ratio shall be used.

D. An annual contribution shall be established which shall be equal to the total sum required to support charity care costs of hospitals between the standard and the disproportionate share level. This sum shall be equally funded by hospital contributions and general fund appropriations.

E. A charity care and corporate tax credit shall be calculated, the numerator of which shall be each hospital's cost of charity care plus state corporate taxes and the denominator of which shall be each hospital's net patient revenues as defined by the Virginia Health Services Cost Review Council.

F. An annual hospital contribution rate shall be calculated, the numerator of which shall be the sum of one-half the contribution plus the sum of the product of the contributing hospitals' credits multiplied by the contributing hospitals' positive operating margins and the denominator of which shall be the sum of the positive operating margins for the contributing hospitals. The annual hospital contribution rate shall not exceed 6.25 percent of a hospital's positive operating margin.

G. For each hospital, the contribution dollar amount shall be calculated as the difference between the rate and the credit multiplied by each hospital's operating margin. In addition to the required contribution, hospitals may make voluntary contributions or donations to the fund for the purpose of subsidizing pilot health care projects for the uninsured.

H. The fund shall be established on the books of the Comptroller so as to segregate the amounts appropriated and contributed thereto and the amounts earned or accumulated therein and any amounts voluntarily contributed or donated for the purpose of subsidizing pilot health care projects for the uninsured. No portion of the fund shall be used for a purpose other than that described in this chapter. Any money remaining in the fund at the end of a biennium shall not revert to the general fund but shall remain in the fund to be used only for the purpose described in this chapter, including any money voluntarily contributed or donated for the purpose of subsidizing pilot health care projects for the uninsured, *whether from private or public sources.*

§ 32.1-338. Distribution of fund moneys.

A. The fund shall compensate a hospital for such hospital's charity care percent less the charity care standard as follows:

1. The payment to each hospital shall be determined as the standard subtracted from each hospital's charity care percent, multiplied by each hospital's gross patient revenues, multiplied by each hospital's cost-to-charge ratio and multiplied by a percentage not to exceed sixty percent.

2. That portion of a hospital's charity care percent which is below the disproportionate share shall be paid from the total amount of the contribution.

3. That portion of a hospital's charity care percent which is above the disproportionate share shall be paid solely from general fund moneys as provided by the General Assembly in the appropriations act.

B. Each hospital eligible to receive a fund payment may elect to return such payment or a portion thereof to the fund to be used at the discretion of the Board, upon the recommendation of the Technical Advisory Panel, for the purpose of establishing pilot health care projects for the uninsured.

C. Money voluntarily contributed or donated to the fund by private *or public* sources, *including local governing bodies,* for the purpose of subsidizing pilot health care projects for the uninsured shall not be included in the calculations set forth in this section.

SENATE JOINT RESOLUTION NO. 308

Requesting the Joint Commission on Health Care, in cooperation with the Secretary of Education, the Secretary of Health and Human Resources, and the State Council of Higher Education, to study the organization and effectiveness of state health workforce reform initiatives.

Agreed to by the Senate, February 23, 1995
Agreed to by the House of Delegates, February 22, 1995

WHEREAS, access to primary health care services is essential for the good health of all Virginians; and

WHEREAS, Virginia currently has an inadequate supply of primary care physicians relative to specialty care physicians; and

WHEREAS, many Virginia localities are experiencing chronic shortages of primary health care providers; and

WHEREAS, the health care system is rapidly evolving toward managed health care delivery systems which require increased numbers of primary health care providers; and

WHEREAS, the Commonwealth has implemented numerous programs to increase the supply of primary health care providers, including (i) the Generalist Initiative for increasing the number of primary care physicians produced by Virginia medical schools, (ii) the Practice Sights Initiative for recruiting and retaining primary health care providers in underserved areas through the use of scholarships, loan repayment programs, provider practice support, and other incentives, (iii) the Area Health Education Centers Program, which supports both the Generalist Initiative and the Practice Sights Initiative through health professions student recruitment and community-based educational programs, (iv) the Office of Rural Health, which supports the Practice Sights Initiative through provider recruitment and retention efforts in rural areas, (v) the Virginia Health Care Foundation, which supports public/private initiatives to recruit and retain primary care providers in underserved areas, and (vi) the Primary Care Cooperative Agreement, which supports primary care needs assessment and planning; and

WHEREAS, these programs involve multiple agencies in both the Education and Health and Human Resources Secretariats, as well as local, federal and private organizations; and

WHEREAS, these programs must be jointly planned and coordinated to address specific needs for primary health care providers in Virginia's local communities; and

WHEREAS, state funding policies for these programs must be based upon careful evaluation of each program and prioritization of the various initiatives; and

WHEREAS, there is no single organization with designated responsibility for coordinating the Commonwealth's health workforce reform initiatives and developing prioritized budget and policy proposals; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Secretary of Education, the Secretary of Health and Human Resources, and the State Council of Higher Education, be requested to study the organization and effectiveness of Virginia's health workforce reform initiatives. The study shall include an evaluation of the need for each program and an assessment of the effectiveness of each program in addressing health workforce needs in the Commonwealth. The study also shall include an evaluation of the most effective organizational structures for (i) conducting a health workforce needs assessment, (ii) coordinating health professions education initiatives with health professions recruitment and retention initiatives, (iii) developing comprehensive budget and policy proposals which integrate the various health workforce reform initiatives and prioritize among individual program goals, and (iv) monitoring progress toward improving the supply of primary health care providers in medically underserved areas.

The Joint Commission on Health Care shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the commission, upon request.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 316

Requesting the Technical Advisory Panel of the Indigent Health Care Trust Fund, in cooperation with the Board of Medical Assistance Services and the Joint Commission on Health Care, to continue its efforts to convert the Indigent Health Care Trust Fund into a program to increase the number of Virginians with health insurance.

Agreed to by the Senate, February 7, 1995
Agreed to by the House of Delegates, February 16, 1995

WHEREAS, approximately one million Virginians do not have health insurance, and another 500,000 Virginians are underinsured; and

WHEREAS, many uninsured Virginians are employed by small businesses; and

WHEREAS, forty-one percent of small businesses do not offer health insurance to their employees; and

WHEREAS, Senate Joint Resolution No. 316 of the 1993 Session of the General Assembly requested the Technical Advisory Panel of the Indigent Health Care Trust Fund, in cooperation with the Board of Medical Assistance Services and the Joint Commission on Health Care, to develop a proposal to reconfigure the Trust Fund to support strategies which will increase the number of Virginians with health insurance; and

WHEREAS, House Bill No. 638 of the 1994 General Assembly authorized the Trust Fund to accept voluntary private donations for the purpose of subsidizing pilot health care projects for the uninsured; and

WHEREAS, the Virginia Hospital Association supports a reconfiguration of the Trust Fund to provide a broader array of health services to uninsured Virginians rather than retrospective payments for charity care; and

WHEREAS, the Technical Advisory Panel has developed a proposal for a pilot program to expand access to health insurance for the working uninsured in Northern Virginia; and

WHEREAS, the pilot program would (i) provide an insurance subsidy, funded by voluntary donations to the Trust Fund, to uninsured employees of small businesses and their families with incomes below 200 percent of the federal poverty level, (ii) use Medicaid reinsurance to lower the total premium cost to eligible workers and their families, (iii) offer comprehensive benefits based on Virginia's Essential Health Insurance Benefits Plan, and (iv) contain costs by using a managed-care model of service delivery; and

WHEREAS, the target date for implementing the pilot program is January 1996; and

WHEREAS, the Technical Advisory Panel is in the process of developing additional pilot programs for the working uninsured in other regions of the Commonwealth; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Technical Advisory Panel of the Indigent Health Care Trust Fund, in cooperation with the Board of Medical Assistance Services and the Joint Commission on Health Care, be requested to continue its efforts to convert the Indigent Health Care Trust Fund into a program to increase the number of Virginians with health insurance.

The Technical Advisory Panel of the Indigent Health Care Trust Fund shall provide staff support for the study. Technical assistance shall be provided by the Board of Medical Assistance Services, the Joint Commission on Health Care, and others as deemed necessary. All agencies of the Commonwealth shall provide assistance to the Technical Advisory Panel, upon request.

The Technical Advisory Panel shall provide the Joint Commission on Health Care by September 1, 1995, a progress report on its efforts to develop programs to increase the number of Virginians with health insurance. The joint commission shall include the report of the Technical Advisory Panel, together with its findings and recommendations for the reconfiguration of the Trust Fund to expand access to health insurance for the uninsured, to the Governor and the 1996 General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 332

Requesting the State Corporation Commission's Bureau of Insurance to study individual and conversion health care coverage and market reform.

Agreed to by the Senate, February 7, 1995
Agreed to by the House of Delegates, February 22, 1995

WHEREAS, health insurance market reforms enacted in 1992, 1993 and 1994 are aimed at improving the access and affordability of health care benefit programs in the small group market; and

WHEREAS, nearly one million Virginians are uninsured, many of whom have limited or no access to group health insurance programs; and

WHEREAS, there are differences between the small group and individual markets such as form and rate filings and other regulatory issues, and there also are many similarities such as the need for access to coverage, portability of coverage, guaranteed renewability, guaranteed issue of essential health care benefit programs, and modified rating requirements; and

WHEREAS, affordability is a particular issue with conversion policies; and

WHEREAS, comprehensive national health care reform was not enacted by Congress and any future national reforms likely will be directed at insurance industry reforms including the individual market; and

WHEREAS, since 1991, fourteen states have enacted various individual market reforms which include portability of coverage, guaranteed issue, guaranteed renewability, rating reforms, and minimum loss ratios; and

WHEREAS, legislation is being introduced during the 1995 Session of the General Assembly as recommended by the Joint Commission on Health Care to limit waiting periods for pre-existing conditions, and provide credit for waiting periods served in previous coverage; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the State Corporation Commission's Bureau of Insurance, in cooperation with the Joint Commission on Health Care, be requested to examine individual and conversion health care coverage and market reform possibilities to determine measures which increase access to affordable health care coverage for such individuals and families.

The State Corporation Commission's Bureau of Insurance shall complete its work in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

GENERAL ASSEMBLY OF VIRGINIA -- 1995 SESSION

HOUSE JOINT RESOLUTION NO. 512

Requesting Virginia's academic health centers, in cooperation with the Area Health Education Centers Program, to develop collaborative training models for physicians and nurse practitioners.

Agreed to by the House of Delegates, February 4, 1995
Agreed to by the Senate, February 21, 1995

WHEREAS, the health care system is undergoing profound changes in response to market forces and public demands for reform; and

WHEREAS, the emerging health care system will be characterized by managed care in which providers must work together to deliver cost-effective services with an emphasis on preventive and primary care delivered in the community; and

WHEREAS, patients in the emerging health care system will often be treated by coordinated teams of health care providers with members from different disciplines including medicine, nursing, allied health, and others; and

WHEREAS, team members will need to possess certain core competencies in order to deliver high-quality, cost-effective care, including (i) the ability to promote community health, (ii) the ability to deliver contemporary clinical care, (iii) the ability to utilize health outcomes research in clinical decision-making, (iv) a commitment to involve patients and families in decision making, (v) the ability to evaluate the cost impact of health care decisions, and (vi) the ability to function collaboratively in a team environment; and

WHEREAS, team members also will need to understand and appreciate the practice scope and professional approach of other disciplines so that they will be prepared to work collaboratively in providing services to patients; and

WHEREAS, the Joint Commission on Health Care, in its 1994 report "Optimum Use of Nurse Practitioners," found that resistance to collaborative practice between physicians and nurse practitioners is in part due to a lack of mutual understanding of the scope of practice and professional approach of physicians and nurse practitioners; and

WHEREAS, the Joint Commission on Health Care further found that collaborative training of medical students and nurse practitioner students would foster improved working relationships between physicians and nurse practitioners; and

WHEREAS, Virginia's academic health centers, including the University of Virginia Health Science Center, the Eastern Virginia Medical School, and the Medical College of Virginia of Virginia Commonwealth University, have made a strong commitment to reforming their educational programs to meet the needs of the 21st century health workforce; and

WHEREAS, the Virginia Area Health Education Centers Program is an important vehicle for facilitating the delivery of health professions education programs in local communities; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia Health Science Center, and the Eastern Virginia Medical School, in cooperation with the Virginia Area Health Education Centers Program, be requested to restructure their instructional programs to provide collaborative training of physicians and nurse practitioners in appropriate settings within the institutions and within communities.

Each school shall report on its progress to the Governor and the General Assembly by October 1, 1995 as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

GENERAL ASSEMBLY OF VIRGINIA -- 1995 SESSION

HOUSE JOINT RESOLUTION NO. 513

Directing the Joint Commission on Health Care to study the organization and effectiveness of Virginia's health care cost and quality initiatives.

Agreed to by the House of Delegates, February 4, 1995
Agreed to by the Senate, February 21, 1995

WHEREAS, health care cost inflation is a continuing problem in Virginia's economy; and

WHEREAS, the effectiveness of many medical procedures is uncertain, leading to wide variations in practice as well as unnecessary expenditures for medical services; and

WHEREAS, information about health care costs and quality has not been sufficient to allow consumers to make informed decisions in the choice of health care plans and providers; and

WHEREAS, as a catalyst for health care reform, the Commonwealth is committed to promoting public/private partnerships for developing consumer information on the cost and quality of health care; and

WHEREAS, in 1992 the General Assembly directed the Virginia Health Services Cost Review Council to develop a new methodology to measure the efficiency and productivity of health care institutions and to identify the most efficient and productive providers; and

WHEREAS, this methodology has been developed by the Williamson Institute of Virginia Commonwealth University under a contract with the Health Services Cost Review Council; and

WHEREAS, in 1993 the General Assembly created the Virginia Patient Level Data System, which is maintained by Virginia Health Information, Inc., a nonprofit, tax-exempt organization operating under a contract with the Health Services Cost Review Council; and

WHEREAS, the Virginia Patient Level Data Base is intended to allow purchasers to compare health care providers in terms of utilization rates, charges, and outcomes for various common or expensive inpatient and outpatient hospital treatments; and

WHEREAS, in 1994 the General Assembly directed the Health Services Cost Review Council to study the feasibility of developing an evaluation system which would allow consumers to compare health plans on measures of cost, quality, and accessibility as well as the role of the Commonwealth in developing such a system; and

WHEREAS, market forces are stimulating health care providers and health plans to place renewed emphasis on cost and quality management through such measures as internal continuous quality improvement programs, public reports on cost and quality indicators, and voluntary accreditation by the National Council on Quality Assurance; and

WHEREAS, the appropriate role of the Commonwealth in developing consumer information on the cost and quality of health care may change depending upon (i) the extent to which the Commonwealth, as a purchaser of health care, uses the information from the Health Services Cost Review Council and the Patient Level Data Base in selecting health care providers and health care plans; (ii) the extent to which the Commonwealth is willing to invest in ongoing research by and development and operations of the Health Services Cost Review Council and the Patient Level Data Base; (iii) the extent to which the private sector is willing to work with the state in supporting these initiatives; and (iv) the pace at which the private sector develops its own cost and quality measurement systems in response to market forces; now, therefore, be it

RESOLVED, by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study the organization and effectiveness of Virginia's health care cost and quality initiatives. The study shall include, but not be limited to, an evaluation of (i) the value of the efficiency and productivity methodology used by the Health Services Cost Review Council, including reports prepared for consumers; (ii) the value of the Virginia Patient Level Data Base, including reports prepared for consumers; (iii) the appropriate role of the Commonwealth versus the private sector as financier, researcher, administrator, and user of health care cost and quality data; and (iv) the appropriate organizational structure and location of the Health Services Cost Review Council and the Virginia Patient Level Data Base.

The Joint Commission on Health Care shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the Commission, upon request.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

GENERAL ASSEMBLY OF VIRGINIA -- 1995 SESSION

HOUSE JOINT RESOLUTION NO. 558

Encouraging Virginia's private sector to continue its support of efforts by the Virginia Health Care Foundation to enhance access to primary and preventive health care for Virginia's uninsured citizens.

Agreed to by the House of Delegates, February 4, 1995
Agreed to by the Senate, February 21, 1995

WHEREAS, the General Assembly, the Governor, and the Joint Commission on Health Care initiated the Virginia Health Care Foundation in June 1992 to promote and support local public/private partnerships that extend primary and preventive health care services to Virginia's one million uninsured citizens; and

WHEREAS, 44 innovative projects involving volunteer, business, and community efforts are currently being funded, including a mobile health clinic, a pharmacy access program, two school-based primary care clinics, several primary care practice sites for family physicians and nurse practitioners, two teen health centers, and an immunization initiative; and

WHEREAS, Virginia Health Care Foundation projects must evidence innovative service delivery models that respond to acknowledged community needs, seasoned local management and leadership, written pledges of cash and in-kind contributions of at least 25 percent, a plan to sustain funding after Foundation grants are depleted, and an evaluation process tailored to desired project impact; and

WHEREAS, while the Virginia Health Care Foundation has granted $3.7 million statewide, it has attracted $5.3 million in cash and $8 million in in-kind contributions at the state and local levels, resulting in a leverage of three dollars and fifty cents in health services for each dollar contributed; and

WHEREAS, in 1994 the Foundation's projects provided primary health care to nearly 30,000 uninsured and underserved Virginians throughout the Commonwealth; and

WHEREAS, the Foundation provides a cost-effective approach to providing primary care, with administrative costs at only six percent of total expenditures; and

WHEREAS, leadership in cash gifts to the Virginia Health Care Foundation at the state level has been provided by Trigon Blue Cross Blue Shield, the Virginia Hospital Association, the Theresa A. Thomas Foundation, INOVA Health System, Johnston Memorial Hospital, First Virginia Banks, Jefferson National Bank, Abbott Laboratories, Virginia Power, the American Tobacco Company, and Kol Bio-Medical Instruments, Inc.; and

WHEREAS, leadership in in-kind gifts to the Foundation at the state level has been provided by Trigon Blue Cross Blue Shield, KPMG Peat Marwick, Cadmus Communications Corporation, McGuire, Woods, Battle & Booth, and the Intergovernmental Health Policy Project of George Washington University; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the General Assembly commend these fine corporate partners for supporting the efforts of the Virginia Health Care Foundation to enhance access to primary and preventive health care for Virginia's uninsured and underserved citizens; and, be it

RESOLVED FURTHER, That the General Assembly encourage Virginia's other corporate citizens to contribute their various talents and resources to the efforts of the Virginia Health Care Foundation.

APPENDIX B:

Status of Past Initiatives

TABLE OF CONTENTS

TABLE OF CONTENTS

GLOBAL REFORMS

Identification of Efficient/Effective Providers

Status: *Efficiency/Productivity Rankings.* First efficiency/productivity rankings were published in December, 1994.

VHSCRC has contracted with the Williamson Institute to develop a methodology to add "quality" indicators to the hospital and nursing home rankings. The Williamson Institute is utilizing patient level data to incorporate quality indicators into a "Mark II" methodology for hospitals. The contract calls for the Williamson Institute to submit a final report regarding hospital quality indicators to the VHSCRC by June, 1995.

A literature search on quality indicators for *nursing homes* has been completed. The Williamson Institute will submit a report to the VHSCRC on the results of the literature search in April.

GLOBAL REFORMS

Identification of Efficient/Effective Providers

Status: *Patient Level Data Base.* The first quarter of patient level data was made available in January, 1995. It has taken substantial effort to develop a data editing process which guarantees an acceptable level of accuracy without placing unreasonable demands on hospitals. A Data Quality Advisory Committee has recently completed work on a quality assurance process which will provide for reasonable data collection standards to be used when assessing fees. The Committee included a diverse group of people including a physician, several hospital representatives, an insurance company representative, a health services researcher, and staff from VHI, VHSCRC, and the Joint Commission.

Patient level data for outpatient services for state-sponsored patients is not yet available. VHI is still working with the Dept. of Medical Assistance Services, the Dept. of Personnel and Training, and Trigon, BlueCross BlueShield to arrange for collection of the data. A key issue to be resolved is who will pay for the programming and associated costs. The initial cost of obtaining state employee data would be $16,500. Ongoing costs are estimated to be $2,400 per quarter.

VHI, Inc. has contracted with the Richmond Area Business Group on Health (RABGOH) to provide computer programming, data analysis/reporting and consulting in support of RABGOH's project to obtain cesarean section data for the Richmond area. VHI, Inc. will develop the methodology, analyze the data and produce reports on cesarean section rates in Richmond area hospitals. The reports are to be completed by May 31, 1995.

GLOBAL REFORMS

Primary Care Workforce Reform

Primary Care Needs Assessment

1991 Requested local health directors to assess primary care needs within their districts.

1993 Requested the Department of Health Professions (DHP) to study the supply and distribution of Virginia's physicians by specialty and location.

Requested the Virginia Statewide Area Health Education Centers Program to: (i) assess Virginia's primary care dental needs and develop a plan for addressing those needs in future years, and (ii) develop a plan by which nurses could assume a more significant role in meeting the primary care needs of the Commonwealth.

1994: Authorized DHP to require health professionals to submit data on practice profiles as part of the licensing process.

Status: A satisfactory data collection methodology has not been established. The problem is that the DHP licensing cycle might not allow development of a reliable data base. DHP has recommended that the VCU Survey Research Laboratory collect the information. However, the cost of this effort would be at least $120,000. Commission staff are working with staff from DHP and other interested parties to develop a workable solution. Also, during the last licensing cycle, DHP decided not to collect physician specialty information as a streamlining measure. This information is important for physician tracking efforts. Staff will be working with DHP and those involved in workforce tracking to decide whether the information should be collected once again or whether other viable sources are available.

GLOBAL REFORMS

Primary Care Workforce Reform

Generalist Initiative

1991 Requested Virginia medical schools to develop a plan to encourage medical students to pursue careers in primary care.

1992 Requested the state academic medical centers to develop plans for emphasizing the education of primary care physicians. The institutions committed themselves to ensuring that 50 percent of their graduates would enter generalist practice.

1993 Appropriated $100,000 to match grant funding from the Robert Wood Johnson (RWJ) Foundation in support of the planning phase of the Generalist Initiative. The goal of the Generalist Initiative is to increase the pool of primary care physicians trained in Virginia's medical schools and residency programs.

1994 Received a three-year, $2.4 million Generalist Initiative implementation grant from the RWJ Foundation. Appropriated $2.65 million for FY 1995 and $1 million for FY 1996 to support implementation of the Generalist Initiative.

1995 Appropriated an additional $1.33 million for FY 1996 to bring the total to $2.33 million. This will be matched with $827,272 in RWJ grant funds and more than $1 million in school funds and other local funds.

Status: The appropriation increase of $1.33 million for FY 1996 is significantly less than the schools' original request of $5.2 million, and even less than the $1.86 million recommended by the Joint Commission. The medical schools and AHEC are restructuring their programs and seeking alternative sources of funding to make up the difference. The RWJ Foundation recently conducted a three-day site visit

GLOBAL REFORMS

Primary Care Workforce Reform

Generalist Initiative

during which the medical schools and AHEC cooperated to provide a thorough status report on the grant.

GLOBAL REFORMS

Primary Care Workforce Reform

Practice Sights Initiative

1992 Virginia won a $100,000 Practice Sights planning grant from the Robert Wood Johnson Foundation.

1993 Practice Sights implementation plan developed with four major objectives:

(i) Continuous refinement of primary care needs assessment
(ii) Establishment of a single office for health professions recruitment and retention
(iii) Development of practice support for primary care office settings in underserved areas
(iv) Development of reimbursement policies to enhance primary care payment rates in underserved areas.

1994 Requested the Department of Health to reallocate resources for purpose of establishing a Center of Health Professions Recruitment and Retention.

Received a three-year, $798,000 Robert Wood Johnson Foundation Practice Sights Initiative implementation grant. This grant is to be matched with more than $500,000 in reallocated state resources.

Status: Staff are working with the Health Department's new Deputy Commissioner for Health Policy to begin full implementation in April, 1995.

GLOBAL REFORMS

Primary Care Workforce Reform

Medical Education Funding

1993 Requested the State Council of Higher Education to study possible fiscal policies and other incentives to stimulate the production and utilization of primary care physicians at the three academic medical centers.

1994 Passed budget language linking medical education funding levels to the goal of 50 percent of graduates choosing generalist residencies. Directed SCHEV to develop specific guidelines and phasing procedures for each school.

Directed Virginia's three academic health centers to develop plans for restructuring graduate medical education programs to reflect a generalist orientation. Preliminary plans were submitted by each institution in the Fall of 1994. A joint plan containing proposals for future graduate medical education planning and funding is due from the institutions in July of 1995.

Status: SCHEV has worked with the schools to develop a phased implementation plan for medical education funding reform beginning in FY 1997 and ending in FY 2000. Schools which meet their targets for graduates choosing generalist residencies could receive funding increases of up to five percent of their normal budget.

GLOBAL REFORMS

Primary Care Workforce Reform

Medical Scholarships

1990 Expanded scholarships for medical students intending to become medical students in Virginia. Appropriated $500,00 for 50 scholarships for each year of the 1990-92 biennium.

1991 Appropriation reduced to $180,000 per year.

1992 Appropriation increased to $360,000 per year.

1993 Appropriation increased to $400,000 per year, and four scholarships were allocated to students from Southwest Virginia.

1994 Appropriation increased to $445,000 per year.

Required the three medical schools to fully match all state funds for scholarships awarded for new applicants at the three medical schools within Virginia as of July 1, 1994. Allowed non-residents of Southwest Virginia to be eligible for scholarships so long as they eventually practice in Southwest Virginia.

Status: For FY 1995, $445,000 was appropriated for the Virginia Medical Scholarship Program. Of 31 full-funded scholarships, 30 were awarded. Of 27 match-funded scholarships, 18 were not awarded. Eastern Virginia Medical School reported that it lacked the funds to provide the match on its nine scholarships. The University of Virginia reported that it could not identify recipients for 8 of its nine match scholarships. Virginia Commonwealth University/Medical College of Virginia could not find a recipient for one of its nine match scholarships.

GLOBAL REFORMS

Primary Care Workforce Reform

Physician Loan Repayment

1990 Established state/federal physician loan repayment program. Appropriated $50,000 in state matching funds. Funds were not spent because federal approval of the program was not obtained until 1993.

1994 Established state-sponsored physician loan repayment program. No funds appropriated.

Status: A total of $100,000 ($50,000 state & $50,000 federal) is available for the state/federal loan repayment program. To date, two physicians are participating in the program. Health Department staff report that the program may be expanded to include nurse practitioners, nurse midwives, and physician assistants in the next funding cycle. They also reported that many physicians find the wholly federal National Health Service Corps Program more attractive because additional money is provided for paying federal taxes.

Nurse Practitioner Scholarships

1993 Appropriated $25,000 in general funds for five nurse practitioner scholarships per year.

1995 Requested an increase of $10,000 to raise the average scholarship amount from $5,000 to $7,000. The request was not approved.

Status: All five scholarships were awarded for FY 1995. Students must agree to work in a state-designated medically underserved area upon completion of their schooling.

GLOBAL REFORMS

Primary Care Workforce Reform

Dental Scholarships

1994 Moved administrative responsibility from VCU/MCV to the Department of Health to consolidate scholarship programs.

Transferred $25,000 in general funds from VCU/MCV to the Department of Health in each year of the 1994-1996 biennium for ten scholarships per year.

1995 Requested an increase of $85,000 to increase the average scholarship amount from $2,500 to $11,000. The request was not approved.

Status: All ten scholarships were awarded for FY 1995. Recipients agree to work in a dental shortage area upon completion of their training.

GLOBAL REFORMS

Primary Care Workforce Reform

Area Health Education Centers Program

1990 Established Statewide Area Health Education Centers Program (AHEC) and appropriated $150,000 per year in state general funds to match federal funds.

1992 Increased annual general fund appropriation to $200,000.

1994 Increased annual general fund appropriation to $240,000.

1995 Increased FY 1996 general fund appropriation to $358,139. Earmarked $118,139 to support AHEC activities related to the Generalist Initiative.

Earmarked $200,000 of the general fund appropriation to the Medical College of Hampton Roads for support of the Eastern Virginia AHEC.

Status: Federal support for the Statewide AHEC program is $1.5 million for federal FY 1995. The Statewide AHEC has recently submitted an application for a three-year, $5.3 million federal continuation grant.

GLOBAL REFORMS

Primary Care Workforce Reform

Prescriptive Authority for Nurse Practitioners

1991 Authorized nurse practitioners to prescribe a limited schedule of controlled substances under the supervision of a physician. The private sector supervision ratio was set at one physician per two nurse practitioners. The public/non-profit sector ratio was set at one physician per four nurse practitioners.

1995 Conformed the private sector supervision ratio to the public/non-profit sector ratio by allowing private physicians to supervise up to four prescribing nurse practitioners at one time.

Status: As of January Virginia had 1,363 licensed nurse practitioners and certified nurse midwives. Of these, 632 had prescriptive authority.

Overall Organization and Management

1995 Requested the Joint Commission on Health Care, in cooperation with the Secretary of Education, the Secretary of Health and Human Resources, and the State Council of Higher Education, to study the organization and effectiveness of state health workforce reform initiatives.

GLOBAL REFORMS

Limits On Physician Self-Referral

1992 Directed the Secretary of Health and Human Resources to study physician ownership and financial interest in health care facilities in Virginia and the subsequent patient referral patterns to these facilities.

1993 Placed limits on physician referrals to health care facilitates outside their office practice at which they do not directly provide care or services when they or an immediate family member have an investment in the facility.

Status: The Department of Health Professions (DHP) reported that the Board has adopted regulations and developed the necessary forms to implement the legislation. In addition, DHP has conducted outreach efforts with providers and others interested in the provisions of the law. To date, no case decisions, requests for exemptions, or advisory opinions have been made. Provisions of the law are not effective until July 1, 1996 for any investments acquired prior to February 1, 1993.

GLOBAL REFORMS

Certificate Of Public Need Reform

1989 Extended the moratorium on new nursing home beds through January 1, 1991. (The moratorium was extended in each Session from 1990 through 1994).

1992 Required that hospital capital expenditures of $1 million or more be regulated under COPN. Also required regulation of the introduction or replacement of certain high technology services such as cardiac catheterization and lithotripsy, among others.

1993 Requested the Secretary of Health and Human Resources to study the utility and feasibility of establishing limits on total capital spending by medical care facilities as a means of discouraging unnecessary expansions of facilities and services. (This study was never conducted).

1994 Extended the moratorium on new nursing home beds through June 30, 1996 and directed the Commissioner of Health, in cooperation with the Department of Medical Assistance Services, to evaluate the continued need for the moratorium.

1995 Passed budget language directing the State Health Commissioner to make an assessment of the five-year budget impact of all Certificates of Public Need issued over the last two years. The study is to be reported to the Chairmen of the House Appropriations and Senate Finance Committees by July 1, 1995.

Status: In the 1994 report on the nursing home bed moratorium, the acting Commissioner recommended that the moratorium not be extended beyond June 30, 1996. The acting Commissioner also recommended that statute should be amended by 1996 to establish a joint request process, administered by DMAS and the Health Department, with strong General Assembly oversight.

MEDICAID REFORM

Program Expansions For Women And Children

1989 Provided funds to support optional Medicaid coverage for children from age 1 to age 2 whose family income is at or below 100% of federal poverty guidelines. (Initial year general fund cost: $200,000).

1991 Provided funds to support mandated coverage of women and children up through age six. (Initial year general fund cost: $30.2 million).

Provided funds to support mandated coverage for: (i) families leaving the Aid to Dependent Children (ADC) program due to increased earnings (12 mo. limit); and (ii) families who qualify for the Unemployed Parent component of the ADC program. Also provided funds to support new eligibles resulting from federal changes in the ADC eligibility guidelines. (Initial year general fund cost: $9.3 million).

1993 Provided funds to support optional phased-in coverage of children under 19 who are not already covered. (Initial year general fund cost: $5 million).

Status: The number of people covered by the Virginia Medicaid program increased from 379, 876 in 1988 to 687,370 in 1994.

MEDICAID REFORM

Medicaid Managed Care

1990 Directed the Department of Medical Assistance Services (DMAS) to study the feasibility of a managed care demonstration project.

1991 Directed DMAS to implement a managed care program for Medicaid patients.

1992 DMAS initiated pilot test of Medallion, a primary care case management program for AFDC recipients.

1993 DMAS initiated state-wide phase-in of Medallion program.

1994 Directed the Department of Medical Assistance Services to implement a voluntary capitated managed care program through the execution of contracts with qualified provider organizations. Led to development of the Options program in which HMOs contract to provide care for Medicaid AFDC recipients.

1995 Expressed legislative intent to expand managed care for the purpose of improving access and containing costs. Directed DMAS to develop detailed implementation plan by September 1, 1995.

Directed DMAS to expand mandatory enrollment in Medallion to all Medicaid recipients except those who receive Medicare and those who participate in community-based waivers effective July 1, 1995.

Directed DMAS to seek the necessary waiver to begin phasing in the Medallion II program in the Tidewater area effective January 1, 1996. Medallion II involves mandatory enrollment in health maintenance organizations except for long-term care clients.

MEDICAID REFORM

Medicaid Managed Care

1995 Directed DMAS to seek the necessary waiver to implement one or more PACE (Providing All-Inclusive Care for the Elderly) demonstration projects.

MEDICAID REFORM

Medicaid Managed Care

Status: *Medallion.* As of February, 1995, 329,024 Medicaid clients were eligible for Medallion. A total of 266,061 were enrolled, and 62,963 were in the process of being enrolled.

Options. As of March, 1995, a total of 15,719 Medicaid clients were enrolled in the Options program. This figure is expected to grow to 23,290 by April. Four HMOs have signed contracts (Optimum Choice, Peninsula Health Care, Sentara Family Care, Priority Health Care).

Managed Care Expansions. DMAS has initiated planning for the managed care expansions approved by the 1995 General Assembly. The plan, due September 1, is to include a phase-in schedule; an assessment of the impact on Medicaid clients; an assessment of the impact on traditional service providers including local health departments, community service boards, academic health centers, and other traditional providers; a detailed quality assurance plan; and assessment of fiscal impact.

MEDICAID REFORM

Limits on Transfer of Assets

1993 Tightened transfer of asset provisions under the Medicaid program in order to limit the Commonwealth's exposure in financing long-term care services in the future.

Status: The 1993 legislation had three components: provisions to allow liens on certain property of Medicaid recipients of long-term care, provisions to allow certain term life insurance policies to be counted as resources of Medicaid long term care applicants, and provisions authorizing the Department of Medical Assistance Services to operate an estate recovery program.

In the process of reviewing regulations to implement the legislation, the Office of the Attorney General (OAG) advised that the language in the bill did not give DMAS adequate authority to place a lien. Legislation was introduced during the 1995 Session to solve this problem. The bill was withdrawn amidst unresolved differences over the OAG interpretation of the statute and the legal process DMAS should have to follow to place a lien. DMAS plans to continue using the other provisions of the legislation and seek a statutory solution to the lien issue during the next General Assembly.

COMMERCIAL INSURANCE REFORM

Small Business Market Reform

1992 Enacted insurance reforms for small groups up to 50 employees. The legislation required guaranteed renewable coverage, disallowed the practice of excluding individuals within groups, and placed limits on pre-existing condition exclusions.

Established the Essential Health Benefits Panel to develop an essential health benefits plan and a standard health services plan for the Commonwealth, and requested the Insurance Commissioner to conduct a study of small group health insurance reform.

1993 Required insurance carriers to guarantee issue for small groups up to 26 employees, imposed modified rating bands, and placed limits on the use of pre-existing condition exclusions. Guarantee issue products are to be patterned after the products developed by the Essential Health Benefits Panel. Effective date of April 1, 1994.

1994 Made several amendments to the 1993 legislation . A key provision is a requirement that insurers participating in the small group market must community rate these groups based on the claims experience for all groups within the insurer's primary small group market. Effective date extended to July 1, 1994.

Status: The Bureau of Insurance was required to promulgate regulations establishing the essential and standard benefit plans. The Bureau is releasing the final regulations today. Carriers desiring to transact business with primary small employers (2-25 employees) will have 180 days to make the essential and standard products available.

COMMERCIAL INSURANCE REFORM

Individual Market Reform

1995 Enacted legislation which: (i) reduces the maximum waiting period for a pre-existing condition from 24 months to 12 months; and (ii) requires insurers, HMOs, and health services plans to provide credit for any waiting periods for pre-existing conditions that an individual has served in a previous group or individual health insurance policy.

Passed a resolution requesting the Bureau of Insurance to examine individual and conversion health care coverage and market reforms.

Status: The Bureau of Insurance is to complete the study in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly.

COMMERCIAL INSURANCE REFORM

Indigent Health Care Trust Fund Reconfiguration (Pilot)

1989 Created a Trust Fund Technical Advisory Panel consisting of state officials and hospital industry representatives.

1990 Expanded the Trust Fund Technical Advisory Panel to include three business representatives and requested the Panel to develop a report on how to bring business representatives into the Trust Fund.

1993 Expanded Technical Advisory Panel to include representatives from the insurance industry, the Commissioner of Insurance, the Virginia Health Care Foundation, and the physician industry.

Allowed hospitals to voluntarily return their Trust Fund payments for use in projects to establish alternative health insurance systems for the uninsured.

Requested the Technical Advisory Panel to develop a proposal to reconfigure the Trust Fund to support strategies for increasing access to health insurance.

1994 Authorized the use of voluntary donations to the Trust Fund to support a pilot program to offer a subsidized insurance product for the working uninsured.

COMMERCIAL INSURANCE REFORM

Indigent Health Care Trust Fund Reconfiguration (Pilot)

1995 Passed a resolution directing the Technical Advisory Panel to continue its efforts to convert the fund.

Authorized the use of local government donations to support Trust Fund pilot projects.

Directed DMAS to seek a Medicaid 1115 waiver which would allow the use of Medicaid funds to provide reinsurance as part of a Trust Fund pilot project in Northern Virginia.

Status: Two hospital systems -- INOVA and Sentara -- have offered voluntary donations of $1.2 million each, to be used for subsidies for the insurance demonstration projects.

DMAS staff are working with the Technical Advisory Panel to develop the specifics of the health plan that will be offered. Virginia Commonwealth University/Medical College of Virginia is attempting to locate funding to support market research for the project.

A concept paper has been submitted to HCFA as a first step toward an 1115 waiver application which would allow the use of Medicaid funds for reinsurance. HCFA has commented that the concept shows sufficient promise to justify further review, but more specifics need to be developed.

The goal is to have the two pilot sites in Northern Virginia and Tidewater operational during the first half of 1996.

COMMERCIAL INSURANCE REFORM

Restrictions On Subscriber Co-Payment Amounts

1994 Required insurers to calculate insured's co-payment amounts on the actual amount paid to the provider of the service, rather than calculating the co-payment based on the provider's full charge.

Status: The Bureau of Insurance monitors insurers' compliance with the law, and reports no problems.

Uniform Claims Form

1993 Established a standardized claims form for providers and insurers in an effort to reduce administrative costs. The law permits the use of different claims forms, but insurers must accept the standardized form.

Status: The Bureau of Insurance monitors compliance with this law, and reports no problems.

PROGRAMS FOR THE UNINSURED

Indigent Health Care Trust Fund

1989 The Indigent Health Care Trust Fund was established as a public/private partnership to address uncompensated charity care for private acute care hospitals. A Technical Advisory Panel was created to oversee the operations of the Trust Fund.

Status: In FY 1994 hospitals participating in the Trust Fund provided charity care costing $79.8 million. Payments from the Trust Fund totaled $10.1 million, with approximately $6.1 million coming from state general funds and $4 million from the hospital industry.

State and Local Hospitalization Program

1989 Transferred the program from the Department of Social Services to the Department of Medical Assistance Services.

Required localities to participate in the program.

Established uniform eligibility criteria for all localities.

Status: The SLH Program approved claims of $28.6 million in FY 1994. Of this amount, the budget was sufficient to pay for $13.2 million worth of claims, leaving $15.4 million in unpaid claims.

PROGRAMS FOR THE UNINSURED

State Teaching Hospitals

1992 Implemented a new funding policy whereby part of the indigent care appropriation was routed through the Medicaid program to obtain federal matching funds under the disproportionate share payment policy.

1993 Requested the Joint Commission to work with the Governor to develop a long-term strategy for the role of the academic medical centers in indigent care and medical education.

1994 Gave the state teaching hospitals flexibility to develop cooperative ventures with private entities in an effort to remain competitive in a changing health care market.

1995 Passed Medicaid budget amendments which included a $12.8 million (federal and state) reduction in planned FY 1996 expenditures for enhanced Medicaid disproportionate share payments at the two state teaching hospitals. This reduction was mostly technical, reflecting a decline in expected inpatient days at the two institutions.

Passed budget language directing the Secretary of Education, in cooperation with the Department of Planning and Budget, VCU, and UVA, to study the feasibility of privatizing the two state teaching hospitals. The study is to be submitted to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 1995.

PROGRAMS FOR THE UNINSURED

State Teaching Hospitals

Status: *Budget.* The state teaching hospital appropriation now comes entirely from Medicaid disproportionate share payments. Planned expenditures for FY 1996 are $90.9 million, of which the state will pay approximately $44.5 million.

Flexibility. VCU has created University Health Services, Inc., as a holding corporation for joint ventures. The board of the corporation includes representatives from the VCU board and staff. Through this mechanism, VCU is pursuing such projects as the purchase of the Blackstone Family Practice and a possible joint venture with local hospitals to provide services at an area nursing home. VCU is also pursuing the creation of a physician-hospital organization involving MCV Hospital and MCV Associated Physicians. Although there are no firm plans for creating a health plan, VCU would like to explore this possibility in the future.

UVA medical center has formed the Blue Ridge Health Alliance with the UVA Health Services Foundation (the faculty practice plan). The major product of this partnership is QualChoice, a licensed HMO with "point of service" options. Enrollment currently includes only UVA health professionals, but the plan will eventually be offered to all UVA employees and other employers in the region. The QualChoice provider network includes Martha Jefferson Hospital and a number of community physicians. UVA is also exploring possible joint ventures with other hospitals in Virginia.

PROGRAMS FOR THE UNINSURED

Virginia Health Care Foundation

1992 Established the Virginia Health Care Foundation to encourage public/private partnerships that provide access to primary care for underserved Virginians. Appropriated $4.6 million in general funds for the 1992-94 biennium.

1993 Increased biennial appropriation to $4.74 million.

1994 Passed a resolution encouraging private entities to support the work of the Foundation.

1995 Reduced FY 1996 appropriation from $2.37 million to $2.23 million and enacted a series of new reporting requirements.

Authorized local health departments to accept private donations for projects conducted under the auspices of the Foundation, as well as other primary and preventive health care projects.

Passed a resolution encouraging continued private sector support of the Foundation.

Status: The Foundation has granted $3.7 million in support of 44 projects across the Commonwealth. Nearly 30,000 uninsured Virginians were served in these projects during 1994. The Foundation has attracted cash contributions of $5.3 million and in-kind contributions worth $8 million. Fifteen Foundation projects will complete their three-year funding cycle in 1996.

PROGRAMS FOR THE UNINSURED

Kids Care

1992 Established the Kids Care program to provide primary and preventive health care services for children under age one with family income from 133% to 200% of poverty, effective July 1993.

1994 Requested a study of universal access to health care for uninsured children and the extent to which current initiatives should be expanded or revised. The report found that Kids Care was covering a small number of children due in part to changes in Medicaid eligibility. Two general options were presented: (i) pursue a federal waiver to expand Kids Care up to age three or four; or (ii) leave Kids Care as a state-only program, integrate with Caring Program for Children; and increase age limit as far as budget would allow.

1995 The biennium Kids Care appropriation of $6 million was eliminated except for a small amount to cover benefits for 39 children currently being served.

Status: Trigon BlueCross BlueShield is in the process of eliminating the Caring Program for Children. The program will cease operation in March of 1996.

LONG TERM CARE REFORM

Restructuring The Long-Term Care System

1992 Requested the Secretary of Health and Human Resources to develop a plan to streamline the planning, administration, and operation of health care and long-term care related boards and agencies.

1993 Established a long-term care policy for the Commonwealth.

Requested the Secretary of Health and Human Resources to reorganize programs serving the elderly at the state level.

Requested the Secretary of Health and Human Resources to develop and implement a statewide comprehensive case management system by July 1, 1994.

Extended the life of the Long-Term Care Council for one year to facilitate the restructure of the system.

Developed a plan to consolidate state long-term care and aging services.

1994 Requested the Secretary to review the consolidation plan and to develop additional plans for the coordinated delivery of services at the state and local levels. Extended the life of the Long Term Care Council through July 1, 1995.

Status: The Advisory Committee on the Consolidation of Long-Term Care and Aging Services has met regularly since January to discuss the local long-term care delivery system. They are currently planning to conduct 10 full day sessions across the Commonwealth to solicit input on the local system from various constituencies including consumers, providers, and local governments. The report for the local plan is due in October of 1995.

LONG TERM CARE REFORM

Adult Care Residences

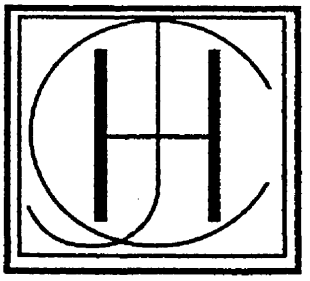
1993 Established a two-tiered licensing system for Adult Care Residences effective January 1, 1994.

1993 Appropriated $1 million in general funds to support the levels of care system for June, 1994.

1994 Appropriated $11.8 million in general funds to support the levels of care system in the new biennium. Rates were contingent upon the adoption of regulations for the levels of care by the Board of Social Services. Regulations were not adopted due to disagreements over the scope of services provided by Adult Care Residences, patient assessment requirements, and staffing standards.

1995 Passed legislation to clarify the original statute. The major provisions of the new legislation clarify the list of conditions which may be treated in an Adult Care Residence; revise staffing requirements; and require an independent assessment of patient needs.

Status: The new legislation requires revisions to the draft regulations and a new public comment period. Target date for implementation is October of 1995.



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